The Journal

of the Michigan State Medical Society

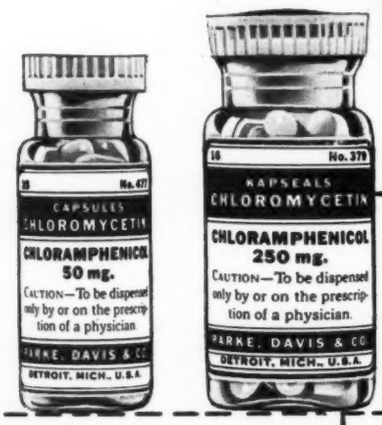
Volume 49 December, 1950 Number 12

Heart to Heart

(See Page 1457)

for rapid response
in the pneumonias

Chloromycetin



98.6

Chloromycetin
(chloramphenicol, Parke-Davis)
is supplied in Kapseals® of 250 mg.,
and in capsules of 50 mg.

PARKE, DAVIS &

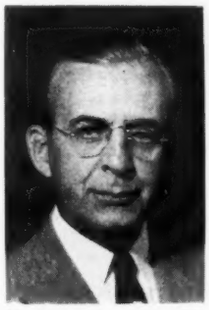
THE JOURNAL
of the Michigan State Medical Society

VOLUME 49 DECEMBER, 1950 NUMBER 12

Contributors to this Issue

GORDON B. MYERS

IVAN F. DUFF



F. JANNEY SMITH

PAUL S. BARKER

L. F. FOSTER

Table of Contents

THE JOURNAL
of the Michigan State Medical Society

VOLUME 49 DECEMBER, 1950 NUMBER 12

Office of Publication
2642 University Avenue
Saint Paul 4, Minnesota

Editor
WILFRID HAUGHEY, M.D.
610 Post Bldg., Battle Creek, Michigan

Secretary and Business Manager of THE JOURNAL
L. FERNALD FOSTER, M.D.
Thorne Bldg., 919 Washington Ave.
Bay City, Michigan

Executive Director
WM. J. BURNS, LL.B.
2020 Olds Tower, Lansing 8, Michigan

All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey M.D., 610 Post Bldg., Battle Creek, Michigan.

All communications regarding advertising and subscription should be addressed to Wm. J. Burns, 2642 University Avenue, Saint Paul 4, Minnesota, or 2020 Olds Tower, Lansing 8, Michigan. Telephone 57125.

Published monthly by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul 4, Minnesota.

Entered at the post office at Saint Paul, Minnesota, as second class matter, May 7, 1930, under the Act of March 3, 1879.

Acceptance for mailing at special rate of postage provided for in Section 1103 Act of October 3, 1917, authorized August 7, 1918.

Yearly subscription rate, $5.00; single copies, 50 cents. Additional postage; Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

PRINTED IN U.S.A.

OFFICERS OF THE SOCIETY

1950-51

President .....C. E. UMPHREY, M.D.....Detroit
President-Elect .....O. O. BECK, M.D.....Birmingham
Secretary .....L. FERNALD FOSTER, M.D.....Bay City
Treasurer .....A. S. BRUNK, M.D.....Detroit
Speaker .....R. H. BAKER, M.D.....Pontiac
Vice Speaker.....J. E. LIVESAY, M.D.....Flint
Editor .....WILFRID HAUGHEY, M.D.....Battle Creek

THE COUNCIL

R. J. HUBBELL, M.D., Chairman, Kalamazoo
WILLIAM BROMME, M.D., Vice Chairman, Detroit
L. FERNALD FOSTER, M.D., Secretary, Bay City

	District		Term Expires
L. W. HULL, M.D.	1st	Detroit	1951
ROBERT S. BREAKEY, M.D.	2nd	Lansing	1955
G. W. SLAGLE, M.D.	3rd	Battle Creek	1955
R. J. HUBBELL, M.D.	4th	Kalamazoo	1951
J. D. MILLER, M.D.	5th	Grand Rapids	1951
R. C. POCHERT, M.D.	6th	Owosso	1951
H. B. ZEMMER, M.D.	7th	Lapeer	1952
L. C. HARVIE, M.D.	8th	Saginaw	1952
E. A. OAKES, M.D.	9th	Manistee	1952
F. H. DRUMMOND, M.D.	10th	Kawkawlin	1952
C. A. PAUKSTIS, M.D.	11th	Ludington	1953
A. H. MILLER, M.D.	12th	Gladstone	1953
W. S. JONES, M.D.	13th	Menominee	1953
J. S. DeTAR, M.D.	14th	Milan	1954
D. BRUCE WILEY, M.D.	15th	Utica	1955
W. D. BARRETT, M.D.	16th	Detroit	1955
W. B. HARM, M.D.	17th	Detroit	1953
WILLIAM BROMME, M.D.	18th	Detroit	1954

C. E. UMPHREY, M.D.....President.....Detroit
O. O. BECK, M.D.....President-Elect.....Birmingham
R. H. BAKER, M.D.....Speaker.....Pontiac
L. FERNALD FOSTER, M.D.....Secretary.....Bay City
A. S. BRUNK, M.D.....Treasurer.....Detroit
W. E. BARSTOW, M.D.....Immediate Past President..St. Louis

EXECUTIVE COMMITTEE OF THE COUNCIL

R. J. HUBBELL, M.D.....Chairman
WILLIAM BROMME, M.D.....Vice Chairman
F. H. DRUMMOND, M.D.....Chairman, Publication Committee
W. S. JONES, M.D.....Chairman, Finance Committee
J. S. DeTAR, M.D.....Chairman, County Societies Committee
R. H. BAKER, M.D.....Speaker, House of Delegates
C. E. UMPHREY, M.D.....President
O. O. BECK, M.D.....President-Elect
L. FERNALD FOSTER, M.D.....Secretary

SECTION OFFICERS

Medicine

J. W. Hall, Jr., M.D.....Traverse City
Chairman
D. I. Sugar, M.D.....Detroit
Secretary

Surgery

L. C. Carpenter, M.D.....Grand Rapids
Chairman
F. P. Husted, M.D.....Bay City
Secretary

Gynecology and Obstetrics

P. E. Sutton, M.D.....Royal Oak
Chairman
L. C. Bosch, M.D.....Grand Rapids
Secretary

Dermatology and Syphilology

H. H. Holman, M.D.....Detroit
Chairman
J. R. Delaney, M.D.....Detroit
Secretary

Radiology, Pathology, Anesthesiology

F. K. Wieterson, M.D.....Detroit
Chairman (Rad.)
H. J. Van Belois, M.D.....Grand Rapids
Vice Chairman (Anes.)
W. A. Stryker, M.D.....Wyandotte
Secretary (Path.)

General Practice

E. H. Fenton, M.D.....Detroit
Chairman
E. N. Smith, M.D.....Grand Rapids
Secretary

Ophthalmology and Otolaryngology

F. B. Heckert, M.D.....Lansing
Chairman (Ophth.)
R. W. Teed, M.D.....Ann Arbor
Co-Chairman (Oto.)
L. E. McCullough, M.D.....Detroit
Secretary (Ophth.)
C. G. Wencke, M.D.....Battle Creek
Co-Secretary (Oto.)

Pediatrics

R. J. Mason, M.D.....Birmingham
Chairman
H. L. French, M.D.....Lansing
Secretary

Urology

C. F. Schroeder, M.D.....Detroit
Chairman
William Bromme, M.D.....Detroit
Secretary

Public Health and Preventive Medicine

O. K. Engelke, M.D.....Ann Arbor
Chairman
M. R. French, M.D.....Hillsdale
Secretary

Nervous and Mental Diseases

J. L. Kubanek, M.D.....Dearborn
Chairman
J. E. Webster, M.D.....Detroit
Secretary

Gastroenterology and Proctology

S. G. Meyers, M.D.....Detroit
Chairman
E. F. Sladek, M.D.....Traverse City
Secretary

DELEGATES TO A. M. A.

Delegates

L. G. Christian, M.D., Lansing.....1951
W. A. Hyland, M.D., Grand Rapids....1951
W. D. Barrett, M.D., Chairman, Detroit.....1952
W. H. Huron, M.D., Iron Mountain..1952
R. L. Novy, M.D., Detroit.....1952

Alternates

H. H. Cummings, M.D., Ann Arbor..1951
E. C. Texter, M.D., Detroit.....1951
R. A. Johnson, M.D., Detroit.....1952
R. H. Denham, M.D., Grand Rapids..1952
C. I. Owen, M.D., Detroit.....1952

County Medical Societies

Branches of the Michigan State Medical Society

SOCIETY	PRESIDENT	SECRETARY
Allegan	E. B. Johnson, M.D., Allegan	J. E. Mahan, M.D., Allegan
Alpena-Alcona-Presque Isle	E. F. Arscott, M.D., Rogers City	Harold Kessler, M.D., 404 N. Second, Alpena
Barry	D. M. Clark, M.D., Hastings	Wesley Logan, M.D., City Bank Bldg., Hastings
Bay-Arenac-Iosco	D. J. Mosier, M.D., Bay City	L. Fernald Foster, M.D., 919 Washington, Bay City
Berrien	N. J. Hershey, M.D., Niles	R. C. Conybeare, M.D., Fidelity Bldg., Benton Harbor
Branch	R. M. Leitch, M.D., Union City	D. T. Culver, M.D., Bronson
Calhoun	F. J. Melges, M.D., Battle Creek	H. R. Bodine, M.D., 1506 Security Natonal Bank Bldg., Battle Creek
Cass	U. M. Adams, M.D., Marcellus	G. T. Britton, M.D., Marcellus
Chippewa-Mackinac	H. M. Harrington, M.D., Sault Ste. Marie	D. A. Cowan, M.D., 140 W. Spruce St., Sault Ste. Marie
Clinton	Bruno Cook, M.D., Westphalia	S. R. Russell, M.D., St. Johns
Delta-Schoolcraft	E. J. Brenner, M.D., Manistique	D. F. LeMire, M.D., 1106 S. First Ave., Escanaba
Dickinson-Iron	H. D. McEachran, Iron Mountain	E. T. Palm, M.D., 412 Superior Street, Crystal Falls
Eaton	B. P. Brown, M.D., Charlotte	A. H. Meinke, M.D., 702 S. Main, Eaton Rapids
Genesee	I. H. Gutow, M.D., Flint	E. P. Griffin, Jr., M.D., 619 Mott Foundation Bldg., Flint
Gogebic	Salvatore Lojacono, M.D., Ironwood	W. H. Wacek, M.D., Grand View Hospital, Ironwood
Grand Traverse-Leelanau-Benzie	Nevin Huene, M.D., Traverse City	D. G. Pike, M.D., 876 E. Front, Traverse City
Gratiot-Isabella-Clare	J. L. Rottschafer, M.D., Alma	L. R. Wickert, M.D., Mt. Pleasant
Hillsdale	L. A. Davis, M D., Camden	I. W. Wiggins, M.D., Jonesville
Houghton-Baraga-Keweenaw	A. M. Roche, M.D., Calumet	A. B. Aldrich, M.D., Hancock
Huron	P. R. Turner, M.D., Harbor Beach	M. G. Sorensen, M.D., Kinde
Ingham	Ralph Wadley, M.D., Lansing	G. D. Cummings, M.D., Mich. Dept. of Health, Lansing
Ionia-Montcalm	H. B. Weaver, M.D., Greenville	Robert E. Rice, M.D., Greenville
Jackson	E. F. Lewis, M.D., Jackson	H. W. Porter, M.D., 505 Wildwood Ave., Jackson
Kalamazoo	H. C. Bodmer, M.D., Kalamazoo	G. H. Rigterink, M.D., 110 Amer. Nat. Bank Bldg., Kalamazoo
Kent	F. L. Doran, M.D., Grand Rapids	J. R. Brink, M.D., Metz Bldg., Grand Rapids
Lapeer	A. T. Rehn, M.D., Lapeer	J. R. Doty, M.D., Lapeer
Lenawee	Homer Isley, M.D., Blissfield	R. E. Dustin, M.D., 307 W. Bidwell, Tecumseh
Livingston	J. J. Hendren, M.D., Fowlerville	R. M. Duffy, M.D., Pinckney
Luce	M. A. Surrell, M.D., Newberry	W. R. Purmort, Jr., M.D., Newberry
Macomb	A. M. Rothman, M.D., Roseville	D. B. Wiley, M.D., 4692 Van Dyke, Utica
Manistee	E. C. Hansen, M.D., Manistee	J. F. Konopa, M.D., 57 Poplar, Manistee
Marquette-Alger	M. C. Bennett, M.D., Marquette	J. R. Acocks, M.D., Morgan Heights San., Marquette
Mason	W. S. Martin, M.D., Ludington	J. R. Carney, M.D., 202 N. Park, Ludington
Mecosta-Osceola-Lake	David Kilmer, M.D., Reed City	J. A. White, M.D., Big Rapids
Medical Society of North Central Counties	R. C. Peckham, M.D., Gaylord	S. A. Stealy, M.D., Box 485, Grayling
Menominee	A. R. Peterson, M.D., Daggett	H. R. Brukardt, M.D., Electric Square Bldg., Menominee
Midland	Martin Ittner, M.D., Midland	H. L. Gordon, M.D., Dow Chemical Co., Midland
Monroe	R. A. Frary, M.D., Monroe	E. J. Sanger, M.D., 3 East Front, Monroe
Muskegon	P. E. Medema, M.D., Muskegon	W. M. LeFevre, M.D., 289 W. Western, Muskegon
Newaygo	B. L. Masters, M.D., Fremont	J. M. Cook, M.D., Newaygo
Northern Michigan	J. B. Conti, M.D., Petoskey	L. E. Grate, M.D., 304 Mason Street, Charlevoix
Oakland	E. B. Cudney, M.D., Pontiac	O. R. MacKenzie, M.D., Walled Lake
Oceana	W. G. Robinson, M.D., Hart	C. H. Flint, M.D., 315 State Street, Hart
Ontonagon	S. H. Rubinfeld, M.D., Ontonagon	W. F. Strong, M.D., Ontonagon
Ottawa	D. C. Bloemendaal, M.D., Zeeland	E. Vander Berg, M.D., Holland
Saginaw	J. W. James, M.D., Saginaw	Robert Bucklin, M.D., 1447 N. Harrison, Saginaw
Sanilac	K. T. McGunegle, M.D., Sandusky	E. W. Blanchard, M.D., Deckerville
Shiawassee	Julius S. Janci, M.D., Owosso	W. L. Merz, M.D., Mason & Ball Streets, Owosso
St. Clair	R. R. Licker, M.D., Port Huron	E. W. Fitzgerald, M.D., 207 Fox Building, Port Huron
St. Joseph	R. A. Springer, M.D., Centreville	C. W. O'Dell, M.D., Three Rivers
Tuscola	F. J. Gugino, M.D., Reese	Walter Pelczar, M.D., Unionville
Van Buren	A. H. Steele, M.D., Paw Paw	J. R. Ralyea, M.D., Paw Paw
Washtenaw	P. H. Bassow, M.D., Ann Arbor	L. Dell Henry, M.D., 118 N. State, Ann Arbor
Wayne	J. J. Lightbody, M.D., Detroit	
Wexford-Missaukee	Robert V. Daugharty, M.D., Cadillac	G. C. Tornberg, M.D., Cadillac

You and Your Business

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

January 31	Mt. Carmel Mercy Hospital Clinic Day	Detroit
February 8	Jackson County Medical Society's Clinic Day	Jackson
March 14-15-16	MICHIGAN POSTGRADUATE CLINICAL INSTITUTE	Detroit
March 17	SECOND ANNUAL MICHIGAN HEART DAY	Detroit
Spring	MSMS Postgraduate Extramural Courses	State-wide
April 3	Calhoun County Medical Society's Clinic Day	Battle Creek
April 4	SECOND MICHIGAN INDUSTRIAL HEALTH DAY	Detroit
April 18	Genesee County Medical Society's Cancer Day	Flint
April	Highland Park Physicians Club Clinic	Highland Park
May 3	Ingham County Medical Society's Clinic Day	Lansing
May 9	Wayne University College of Medicine Alumni Association Clinic Day and Reunion	Detroit
May 22	Bon Secours Hospital Clinic Day	Grosse Pointe
June	St. Clair County Medical Society's Clinic Day	St. Clair
June	Upper Peninsula Medical Society Annual Meeting	
July 26-27	Annual Coller-Penberthy Medical-Surgical Conference (sponsored by Grand Traverse - Leelanau - Benzie County Medical Society)	Traverse City
Sept. 26-27-28	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION	Grand Rapids
October 13	Third Michigan Cancer Conference	East Lansing
Autumn	MSMS Postgraduate Extramural Courses	State-wide
Oct. or Nov.	American Academy of General Practice of Wayne County	Detroit
November 7	Clara Elizabeth Fund Lectures (sponsored by Genesee County Medical Society and the Clara Elizabeth Fund for Maternal Health)	Flint

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of October 19, 1950

- At this meeting, held in Lansing, seventy-five separate items were presented, discussed, and acted upon by the Executive Committee of The Council which was in session from 10:45 a.m. to 10:00 p.m. The highlights were as follows:
- Monthly financial reports, including break-down of the Public Education Account and of the Public Education Reserve Account, were presented, studied in detail, and approved.
- Bills payable for the current month were presented, approved, and payment was authorized.
- Invitational membership campaign. As a means of offsetting a drop in the active membership due to hundreds of transfers in 1951 to Military Membership, the Executive Committee authorizes the institution of an invitational membership drive by MSMS and county medical societies and the reprinting of the leaflet "Benefits of the Membership in Medical Societies" for use in this campaign.
- Matters referred to The Council by the 1950 House of Delegates: (a) Report was given that the attempt to bargain away medical services —made by two large employers—had been invited to the attention of the membership, and further contacts with employers' associations were authorized; (b) Committee of Seven to Study Basic Science Law. The President announced this Committee: J. D. Miller, M.D., Chairman, Grand Rapids, W. B. Harm, M.D., Detroit, Mr. J. Joseph Herbert, Manistique, J. E. Livesay, M.D., Flint, J. H. Schlemer, M.D., Detroit, E. D. Spalding, M.D., Detroit, and D. B. Wiley, M.D., Utica; (c) Study of Nursing Needs. This resolution was referred to the Permanent Conference Committee for advice and report back to The Council; (d) Development of simplified insurance reporting forms. Information on the work done on this subject by the AMA and by other state medical societies is to be obtained with report back to The Council at the earliest possible date; (e) Change in the Coroner system. This was referred to the

(Continued on Page 1364)

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1362)

MSMS Legislative Committee for study and report back to The Council. Other matters referred by the House of Delegates were delegated to the MSMS Executive Director or to the Public Relations Department for execution.

- Rheumatic Fever Centers—exempt from income tax. A communication dated October 3, 1950 from the Office of Commissioner of Internal Revenue, U. S. Treasury Department, declared that the Michigan Rheumatic Fever Control Centers are entitled to exemption from federal income tax under the provisions of Section 101 (7) of the Internal Revenue Code, because the Rheumatic Fever Control Centers are a committee activity of the Michigan State Medical Society which was ruled exempt under this Section on May 22, 1944.
- Hospital standardization. The announcement from the American College of Surgeons that it was relinquishing its hospital standardization program was reported and thoroughly discussed. The Executive Committee of The Council instructed that notification be sent to ACS, AMA, and other interested organizations protesting against this relinquishment by the ACS of its hospital standardization program and encouraging its transfer to the American Medical Association.
- A request from the Director of the Social Security Department of the UAW-CIO for a meeting with a committee of the Michigan State Medical Society to study the medical and health aspects of life pensions to persons who become permanently and totally disabled, was presented and a study committee to explore and to report back to The Council was appointed: O. O. Beck, M.D., Chairman, Birmingham, William Bromme, M.D., Detroit, D. H. Kaump, M.D., Detroit, J. E. Livesay, M.D., Flint and C. W. Brainard, M. D., Battle Creek.
- *Detroit Times* editorial. A letter of commendation to the *Detroit Times* on the excellence of an editorial "Fighting for Her Life," published October 19, 1950, was authorized.
- Average age of members of The Council. The Secretary reported that the average age of council members at this time is 54.9 years.
- White House Conference, Washington, D. C., December 3 to 7. Frank Van Schoick, M.D., Jackson, and H. B. Zemmer, M.D., Lapeer, were authorized to attend this Conference as MSMS representatives.
- 1954 MSMS Annual Session in Detroit. The dates of this meeting were set as September 29-30, and October 1, 1954.
- Doctors of medicine to stagger half-holidays. The Executive Committee of The Council discussed the problem of lack of medical service at all times and instructed that all efforts be made to solve same through immediate contacts to be made by MSMS Councilors and county medical society officers with publicity to their membership, especially urging that doctors stagger their half-holidays.
- Change in MSMS By-Laws re-election of Alternate Delegates. This subject was referred to the Committee on Constitution and By-Laws.
- J. A. Witter, M.D., Detroit, was appointed MSMS representative to the Legislative Committee of the Michigan Nursing Center Association.
- Legal Counsel J. Joseph Herbert invited attention to the recent decision of Judge Claude McColloch, U. S. District Court, Portland, Oregon, throwing out the Government's case against the Oregon State Medical Society et al. He also presented opinion on the sixty-day billing clause of the Michigan Crippled Children Commission (which is covered by law, not by MCCC rule).
- Mr. Herbert was authorized to develop an opinion on the subject of hospital records and authorization to attorneys to study same, with or without the patient's, the doctor's, and the hospital's consents.
- The Public Relations Counsel advised that 1,469 column inches of space had been devoted in newspapers to the 1950 MSMS Annual Session; a total of 14 talks were presented over the radio, television and before luncheon clubs during the three days of the Annual Session in Detroit.
- A letter of commendation to Robert Goldman of the *Detroit Free Press* was authorized. Mr. Goldman, Ace science writer and contributor of much accurate information to the public on medical matters, is leaving the *Detroit Free Press* for private business.
- Mr. Brenneman reported that the MSMS motion picture "To Your Health" has been shown in

(Continued on Page 1366)

in active rheumatoid arthritis, the "best agent . . . that is readily available."[1]

Many therapeutic agents have been advocated for the treatment of active rheumatoid arthritis, with varying degrees of success. Among those now generally available, gold is "the only single form of therapy which will give significant improvement."[2]

SOLGANAL® for intramuscular injection is practical and readily available therapy. It acts decisively, inducing "almost complete remission of symptoms" in fifty per cent of patients and definite improvement in twenty per cent more.[3]

Detailed literature available on request.

Suspension SOLGANAL in Oil 10, 25 and 50 mg. in 1.5 cc. ampuls; boxes of 1 and 10 ampuls. Multiple dose vials of 10 cc. containing 10, 50 and 100 mg. per cc.; boxes of 1 vial.

SOLGANAL®

(aurothioglucose)

BIBLIOGRAPHY (1) Holbrook, W. P.: New York Med. (no. 7) 4:17, 1948. (2) Ragan, C., and Boots, R. H.: New York Med. (no. 7) 2:21, 1946. (3) Rawls, W. B.; Gruskin, B. J.; Ressa, A. A.; Dworzan, H. J.; and Schreiber, D.: Am. J. M. Sc. 207:528, 1944.

Schering CORPORATION · BLOOMFIELD, N. J.

SOLGANAL

SCHERING

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1364)

192 Michigan theaters and "Lucky Junior" has appeared in 239 Michigan theaters.

- Committees of The Council for 1950-51, as appointed by Chairman R. J. Hubbell, M.D., were presented to and approved by the Executive Committee of The Council (list to be published quarterly in JMSMS).
- The following committee reports were given consideration: (a) Special Committee on Education, meeting of October 17; (b) Mental Hygiene Committee, meeting of September 27; (c) Mediation Committee, meeting of September 20; (d) Committee of Ophthalmologists, meeting of September 20; (e) Health Survey Advisory Committee, meeting of October 4; (f) Medical Procurement Advisory Committee, meeting of September 27.

1951 MSMS DUES SET AT $45.00

The House of Delegates of the Michigan State Medical Society, at its Detroit session of September 18-19, 1950, set the MSMS dues for the year 1951 at $45.00. At the same time, the House of Delegates eliminated the $25.00 assessment which had been levied on every MSMS member for some years in the past.

The 1951 dues represents a net increase of $8.00 over the former $12.00 dues plus the $25.00 assessment.

E. A. Osius, M.D., Detroit, Chairman of the MSMS Finance Committee, explained to the House of Delegates that the $12.00 dues had not met the expenses of the General Fund of the State Society for the years 1948, 1949 and 1950. In fact, The Council had found it necessary to allocate $5.00 of the Educational Fund ($25.00 assessment) to the General Fund in the year 1950 in order to meet current expenses. Dr. Osius stated that the $8.00 increase was necessary to offset higher office and routine operating expenses of the General Fund caused by decreased purchasing power of the dollar; in addition it would tend to offset loss of revenue due to many Active Members being transferred to Military Membership, a non-dues paying classification.

A continuance of the progressive work of the Michigan State Medical Society, plus maintenance of the current high level of public relations activity, will be possible with the increase in dues, according to Dr. Osius, who reported that other outstanding state medical societies such as California, Colorado, Oregon, etc., have annual dues of $50.00 or more.

Dues in professional societies are deductible in income tax reports, while the charging off of assessments is debatable.

1951 MPCI FEATURES 34 STARS ON PROGRAM—MARCH 14-15-16

The Fifth Michigan Postgraduate Clinical Institute, to be held at the Book-Cadillac Hotel, Detroit, Wednesday, Thursday, Friday, March 14-15-16, 1951, will present the following speakers: Wesley W. Spink, M.D., Minneapolis; R. R. Grinker, M.D., Chicago; David A. Boyd, Jr., M.D., Rochester, Minnesota; Willard O. Thompson, M.D., Chicago; Willis E. Brown, M.D., Little Rock, Arkansas; Evarts A. Graham, M.D., St. Louis, Missouri; Stanley Gibson, M.D., Chicago; John E. Gordon, M.D., Boston; Russell S. Boles, M.D., Philadelphia; Allan C. Barnes, M.D., Columbus, Ohio; Francis D. Moore, M.D., Boston; Charles A. Ragan, Jr., M.D., New York City; W. Paul Holbrook, M.D., Tucson, Arizona; George Kamperman, M.D., Detroit; Clifford D. Benson, M.D., Detroit; Noyes L. Avery, Jr., M.D., Grand Rapids; Angus G. Goetz, M.D., Detroit; John M. Sheldon, M.D., Ann Arbor; Ivan F. Duff, M.D., Ann Arbor; J. Milton Robb, M.D., Detroit; Robert H. Denham, M.D., Grand Rapids; Osborne A. Brines, M.D., Detroit; Gordon B. Myers, M.D., Detroit; Lawrence Reynolds, M.D., Detroit; G. Thomas McKean, M.D., Detroit; Warren K. Wilner, Jr., M.D., Ann Arbor; Arthur C. Curtis, M.D., Ann Arbor; Albert D. Ruedemann, M.D., Detroit; A. J. French, M.D., Ann Arbor; Harold J. Kullman, M.D., Dearborn; Harry A. Towsley, M.D., Ann Arbor; Reed M. Nesbit, M.D., Ann Arbor; Frederick C. Swartz, M.D., Lansing; and Jerome W. Conn, M.D., Ann Arbor.

The detailed program of the Michigan Postgraduate Clinical Institute will be published in the January Number of JMSMS.

MICHIGAN HEART DAY, SATURDAY, MARCH 17, 1951

The Second Annual Michigan Heart Day, sponsored by the Michigan Heart Association, will hold the stage at the Grand Ballroom, Book-

(Continued on Page 1368)

MICHIGAN HEART DAY

(Continued from Page 1366)

Cadillac Hotel, Saturday morning, March 17. The Program is as follows:

9:00 a.m. "920 Cases of Myocardial Infarction —A Study of the Acute Phase."
F. JANNEY SMITH, M.D., Henry Ford Hospital, Detroit.

10:00 a.m. "Blood Lipids and Human Arteriosclerosis."
HARRY E. UNGERLEIDER, M.D., Medical Director, The Equitable Life Assurance Society, New York.

11:00 a.m. "The Present Status of ACTH and Cortisone in Rheumatic Fever."
ALBERT DORFMAN, M.D., The University of Chicago, Chicago, Illinois.

12:00 noon Luncheon—To be followed by the Second Annual Meeting of Members of the Michigan Heart Association.

All MSMS Members are cordially invited to attend the Institute and Heart Day programs.

INSURANCE DEPARTMENT HAS APPROVED NEW BLUE SHIELD $5,000 CONTRACT

The Insurance Department, in Lansing, has approved the new Blue Shield $5,000 family income ceiling contract. All doctors of medicine in the state are now being informed by letter that Michigan Medical Service is prepared to offer the new contract to the public.

Signed by R. L. Novy, president of Michigan Medical Service, and approved by the Executive Committee under the authority of the Board of Directors, the letter being mailed to all doctors clarifies the purpose and background of the new contract:

1. The new contract will *not* replace the present $2,500 family income ceiling contract. They will be offered together to all groups. According to Michigan Medical Service, the members in each enrolled group will have a choice of either the $5,000 or the $2,500 contract, depending on each individual's income.

2. The fee schedule for the $5,000 contract provides benefits that are about 40 per cent on the average above those provided by the $2,500 contract.

3. The fee schedule for the $5,000 contract is based on a state-wide survey of charges authorized by the State Medical Society. It has been approved by both the Council of the State Medical Society and the Board of Directors of Michigan Medical Service.

4. The action to establish the $5,000 contract was authorized by the House of Delegates of Michigan State Medical Society in September, 1949. The House of Delegates has since repeatedly endorsed every step taken toward the realization of the $5,000 family income ceiling contract.

Following is the letter being mailed to all doctors in Michigan:

Dear Doctor:

Your interests are vitally involved in the $5,000 family income contract. *It is important to you that you read this letter carefully.*

Michigan State Medical Society in 1939 founded Michigan Medical Service to provide prepaid medical care for the people of Michigan. Because 80 per cent of the families in the state had incomes of $2,500 or less, a $2,500 income ceiling was established. However, by 1948 the situation reversed itself, so that 80 per cent of the families had annual incomes of $2,500 or more.

The changed economic situation motivated a revaluation of the income ceiling. Knowing that the public needs an effective prepayment medical plan, your House of Delegates in 1949 and 1950 instructed that a second service contract for families with annual incomes up to $5,000 be established, and repeatedly endorsed every effort in that direction.

Carrying out the instructions, your Medical Service is now prepared to issue a service contract for families with incomes below $5,000. *The present $2,500 family income contract will be continued.*

A schedule of fees or benefits for the $5,000 contract has been developed. The contract covers both medical and surgical services *and applies only to patients using ward or semi-private accommodations, as does the present $2,500 contract.*

A survey of charges to provide a practical base for a fee schedule for the $5,000 contract was authorized by the State Medical Society in 1950. The response of the doctors to the survey revealed an interest in the problem that exceeded all expectations. The replies were tabulated, averaged and analyzed. The new $5,000 fee schedule, based upon the survey, will provide benefits of about 40 per cent more than the $2,500 schedule of benefits. The new fee schedule is enclosed. It has been approved by the Council of the State Medical Society and by the Board of Directors of Michigan Medical Service.

Also enclosed is a specimen copy of the new $5,000 certificate. Parts printed in red indicate the differences between it and the present $2,500 certificate.

There are at present 4,851 doctors of medicine who have signed participating agreements (copy attached) to provide "medical services under the service plan of Michigan Medical Service, a nonprofit corporation," et cetera. The agreement further provides: "It is understood that I may at any time discontinue enrollment in the Michigan Medical Service plan by giving fifteen days' notice in writing to Michigan Medical Service."

We will assume that if you are one of the 4,851 doctors you will continue to contribute to this new program, unless we hear from you to the contrary.

This contract is the Michigan State Medical Society's answer to the need for meeting today's inescapable economic conditions.

Very truly yours,
R. L. NOVY, M.D., *President*

Approved by the Executive Committee
under authority of the Board of Directors
of Michigan Medical Service.

....PRONESTYL *Hydrochloride*

less toxic than quinidine

Indications and Dosage

IN CONSCIOUS PATIENTS

For the treatment of ventricular tachycardia:

Orally: **1 Gm. (4 capsules) followed by 0.5-1.0 Gm. (2 to 4 capsules) every four to six hours as indicated.**

Intravenously: **200-1000 mg. (2 to 10 cc.). *Caution*—administer no more than 200 mg. (2 cc.) per minute.**

Hypotension may occur during intravenous use in conscious patients. As a precautionary measure, administer at a rate no greater than 200 mg. (2 cc.) per minute to a total of no more than 1 Gm. Electrocardiographic tracings should be made during injection so that injection may be discontinued when tachycardia is interrupted. Blood pressure recordings should be made frequently during injection. *If marked hypotension occurs, rate of injection should be slowed or stopped.*

For the treatment of runs of ventricular extrasystoles:

Orally: **0.5 Gm. (2 capsules) every four to six hours as indicated.**

IN ANESTHESIA

During anesthesia, to correct ventricular arrhythmias:

Intravenously: **100-500 mg. (1 to 5 cc.). *Caution*—administer no more than 200 mg. (2 cc.) per minute.**

Supply

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

PRONESTYL *Hydrochloride*

SQUIBB PROCAINE AMIDE HYDROCHLORIDE

SQUIBB

PR In Practice

In every war, periods of calm come after great battles are waged. Such moments-of-pause permit sound evaluations of progress and dispassionate appraisals of the tasks that yet remain before complete victory is won.

It is no secret that the medical profession is embattled in an ideological conflict that can only result in victory or defeat for a way of life that is summed up in the single word—*American.* Michigan doctors of medicine have just completed a great battle—the Good Citizenship Campaign —which played a major role in that conflict. This has been superimposed upon and correlated with the ever growing year-round public relations program which is the mechanism for continued progress.

It is necessary that at this time we quickly review what has been accomplished by our Good Citizenship Campaign and then gird our minds and our forces into an alignment that will not only maintain the advantages gained but will continue the program smoothly and powerfully.

May 7 to November 7

On May 7, 1950, the Good Citizenship Campaign was launched. Medical representatives from every area of the state gathered to pool their efforts to plan and implement a program designed to get out the vote and to halt the epidemic of socialism that was spreading in Michigan. Each representative returned to his local area and carried the message of "Here's how it can be done." CAP Committees from each of the 55 county medical societies and from the Woman's Auxiliaries went to work to get people registered and then get out the vote. Reports showed that 97.4% of the doctors of medicine, 97.3% of their wives, and 90.4% of their medical assistants registered. "Lists of 20" were combed carefully to see that the 100,000 persons represented in these lists were registered. Headquarters personnel of 40 statewide business and professional organizations were individually contacted and urged to participate in the campaign. With one exception they enthusiastically joined in. Each in its own way—by letters, bulletins, journals, special meetings, etc.—alerted its members. Supplies went out to their local groups —advertisements, counter display cards, imprinted napkin, window displays, reminder-to-vote cards, announcements, radio broadcast scripts, ideas for local promotion, etc. Many of these were originated by the MSMS office and turned over to these other organizations. The MSMS itself sent between 250,000 and 300,000 letters, postcards, etc.

Also included in the MSMS State-wide campaign were radio and television programs, the advertising campaign of the American Medical Association (involving a paid ad by the AMA) in every Michigan newspaper, tie-in ads by scores of other groups, and paid radio spot announcements on 26 radio stations, an active speakers bureau that supplied speakers on every occasion requested. A final fighting speech outlining the stand of the MSMS in the election was presented over Radio Station WJR, Detroit, by MSMS Secretary L. Fernald Foster, M.D.

Many county medical societies levied special local assessments to help in defraying the expenses of their efforts to "Get Out the Vote."

County Woman's Auxiliaries developed meetings of women's groups, carried on telephone campaigns, wrote thousands of letters.

Election Day Turnout Great

On Election Day, house to house canvasses, phone committees, motor pools and 134,210 reminder to vote cards brought thousands of extra voters to the polls.

In addition to the above efforts, all of which were non-partisan, many doctors and their wives —as individuals—joined in active work locally for one party or the other and campaigned vigorously. There is no way of knowing the total extent of this effort but the fact that activity by M.D.'s was present in every section, city and hamlet of the state was obvious.

A record breaking turnout at the Primary polls in September gave encouragement and the campaign was stepped up prior to the General Election on November 7.

On General election day the largest turnout of voters ever to go to the polls in a non-presidential election was recorded in Michigan.

(Continued on Page 1374)

(Continued from Page 1372)

MSMS Public Relations Work Continues

Meanwhile the general public relations activity of the medical profession in Michigan continued. The "Tell Me, Doctor" program, nationally recognized as the only daily medical radio program in the United States, passed its 1,200th broadcast. The two motion pictures developed by the MSMS —"Lucky Junior" and "To Your Health" were exhibited in 241 and 210 theaters, respectively. Rights to the latter named picture were sold to seven other state medical societies in the United States for showing in theaters and loaned for showing to hundreds of small groups.

The Michigan Health Survey was completed and copies sent to 5,000 M.D.s in Michigan. A weekly twenty-minute television program, "It's Your Life" over WXYZ-TV and other television stations in Michigan was developed. Support was given the Michigan Health Council in its development of twenty-seven new Community Health Councils. A national conference on M.D.s participation in Health Councils was held in Detroit, October 1, jointly sponsored by the AMA and the MSMS. The Michigan Rural Health Conference was held at Michigan State College, East Lansing, powerfully backed by the MSMS. Resolutions opposing socialized medicine to a total of 331 were reported to the MSMS Executive Office. Outstanding publicity was obtained in connection with the MSMS Annual Session and the Michigan Postgraduate Clinical Institute. During the 1950 Annual Session, in addition to hundreds of inches of newspaper space, 14 presentations were made over radio and television and before service clubs in the Wayne County area.

Recognition in national lay publications of the United States has been given the MSMS public relations program as well as in the professional public relations journals.

Too often but a few persons are credited with the success of a program such as that outlined above. Although there are a few persons under whose direction the program is carried out, yet the extent and success of the entire effort is due to the unswerving devotion of the entire membership of the MSMS to the principles that have made American Medicine great. From this devotion has come a united effort, only partially reflected in the statistics above, that will keep America great—and free.

Where Do We Go From Here?

No question remains about the victory gained against socialism in the last election. It was definite if not complete. Across the country many of those whose names were closely linked with socialistic-sided legislation were removed from office.

But certains things were obvious. These were:

That the proponents of socialism in America are prepared and committed to continue their efforts and that huge resources to influence public opinion are at their command;

That, upon the progress made in the next eighteen months, by either side, depends the fate of America; and that only if we falter and stumble in our new found strength will those who gave their time during this past year be betrayed.

Where do we go from here? That's up to you!

AVERAGE AGE OF COUNCILORS

The average age of members of The Council of the Michigan State Medical Society, 1950-51, is surprisingly low. A recent survey indicates that the average age of the members of the MSMS "board of directors" is only 54.9 years.

The youngest Councilor is aged forty-one and the eldest is sixty-nine.

Five Councilors are in their forties; twelve are in their fifties; and six are in their sixties.

SQUIBB ABSTRACT BULLETIN

The *Squibb Abstract Bulletin* is now available to individuals and institutions on a subscription basis at $25 a year, it has been announced by Dr. Geoffrey Rake, director of The Squibb Institute for Medical Research and medical director of E. R. Squibb & Sons.

The *Bulletin,* now in its twenty-third year of publication, is issued weekly. Abstracts of articles from approximately 500 American and European journals in the fields of medicine, pharmacology, chemistry and biochemistry are included. Each weekly issue contains nearly 100 abstracts, and each gives some 115 title listings of additional papers sometimes with a brief indication of the contents. The abstracts represent those papers which are considered to be most important. An annual author index is published and each issue gives subject headings with individual entries.

Abstracting is unusually prompt; the bulk of the material appears in the *Bulletin* within three weeks after receipt of the journals in the Squibb library.

The *Squibb Abstract Bulletin,* can be subscribed to in multiple copies, with $25 being the annual charge for the first copy and $15 for additional copies. Copies printed on only one side of the page and which are thus suitable for clipping are available at the same price.

Opinion on Oregon Physicians' Service

UNITED STATES DISTRICT COURT
DISTRICT OF OREGON

UNITED STATES OF AMERICA
Plaintiff

vs.

OREGON STATE MEDICAL SOCIETY et al
Defendants

OPINION, FINDINGS AND NOTES
OF THE TRIAL JUDGE

The trial judge states: The government contends (1) that defendants, beginning about 1936, conspired to restrain and monopolize prepaid medical care "in the State of Oregon"; (2) that "each of the medical societies" (Oregon State Medical Society and eight county and regional societies) "attempted to restrain and monopolize prepaid medical business in areas where they operate"; and (3) that "each of the medical societies (Oregon State Medical Society and eight county and regional societies) did restrain and monopolize prepaid medical business in areas where they operate."

I hold that none of the Government's charges have been proven by a preponderance of the evidence.

I hold that *Oregon Physicians' Service* is not a conspiracy but, rather, an entirely legal and legitimate effort by the profession to meet the demands of the times for broadened medical and hospital service, eliminating the evils of privately owned concerns as well as the element of private profit.

I will make a finding that the defendants did not conspire to restrain and monopolize prepaid medical care in the State of Oregon.

I will make a finding that defendant medical societies did not attempt to restrain and monopolize prepaid medical business in areas where they operate by express agreement or concert of action within their own groups or with third parties.

I will make a finding that defendant doctors and medical societies have not restrained or sought to restrain the use of hospital facilities by others, except in cases of lawful and legitimate professional discipline of individual doctors for unprofessional conduct detrimental to their patients, to the hospitals and to the public generally.

The Government says regardless of motive, if the necessary result of action is monopoly, the statute applies. But I find (1) that the motive (intent) of defendants was not to restrain or monopolize; and (2) that monopoly did not in fact result and does not exist. Nor does unreasonable restraint exist.

I will make a finding that if there was a conspiracy, as alleged by the Government, the thread was broken and the conspiracy ended when a large percentage of Oregon doctors entered the Armed Forces in the period 1941-1945.

I will make a finding that OPS and the doctor-owned county and regional plans are business competitors with the privately owned profit-making organizations and that, as competitors, the doctors have conducted their organizations fairly and well within the legal limitations of competitive business practice.

I will make a finding and/or conclusion that the practice of medicine is not a trade within the meaning of the Sherman Law.

I will make a finding that OPS and the various county or regional doctor-owned or doctor-sponsored prepaid medical plans were not formed to eliminate or restrain organizations already in the field; on the contrary, they were formed to meet the social need which had arisen for group medical care, eliminating the element of private profit, over and above legitimate hospital and medical charges.

I will make a finding and/or conclusion that defendants have not in recent times (if ever) boycotted privately owned hospital associations, and that they do not, so far as the evidence or legitimate inferences show, intend to boycott privately owned hospital associations in the future.

(The Judge calls the Government a liar. Page 455, Government's Brief, states a greater per cent of Oregon is covered by prepaid plans than in any other state. The Judge found only 120,000 out of 1,510,000 people in the state belong to OPS.)

The Government charges that OPS is engaged in a conspiracy to monopolize *statewide* prepaid medical care, but OPS is criticized because it does not go into certain counties.

(Continued on Page 1378)

(Continued from Page 1376)

Fee Fixing

Of course, if the professions are trades, then fee schedules become (under Supreme Court decisions) *per se* unlawful.

The question of fee fixing has become academic in the present case because the case revolves around the legitimacy of the operations of the doctors in competition with the privately owned plans. The Government concedes the right of the doctors to compete in this field and the fixing of fees is of the very essence of all prepaid plans, whether doctor-owned or privately owned.

The Supreme Court has held that Organized Labor does not come under the anti-trust laws. This was court-made law.

Can it be justly contended that the Congress intended to include the professions when it enacted the Sherman Law in 1890? The American Medical Association had been in existence 43 years. The American Bar Association was organized in 1878.

The Age of the Common Man

In a measure, this case is an attack on the professions. Everything critical of the doctors that has been said in the case could be said of the legal profession.

The World Revolution that we hear about allows no place for the professions. All that is principle, dignity, the efforts of the ages to create an aristocracy of intellect—these are to be destroyed in the interest of "the common man."

He will be "common," indeed, without professions in the society which he is to rule.

Self-preservation

Leaders among the doctors maintain the view that doctor-owned prepaid medical plans are the profession's answer to socialism.

Can it be that a profession may not defend itself by reorganization of its methods, by doing within the profession what has been compelled elsewhere by law; that, thus, to reorganize and seek to preserve its independent status makes an organized profession and its leaders criminals and subject to the injunctive power of the courts?

In short, that organized medicine must remain a sitting duck while socialism overwhelms it? I would not expect an American court to hold that.

Socialized Medicine may overtake them but the doctors claim the right to save the profession from socialism. That is what this case is about, according to the doctors' viewpoint. As to this defense it must be conceded that the purpose with which action is taken is of prime importance under the Sherman Act.

What was the purpose of the doctors in organizing the Oregon Physicians' Service? Was it to obtain a monopoly in the prepaid medical field, or was it to save themselves and their profession from threatened socialization? I hold it was the latter and that nothing in the anti-trust laws deprives them of the right to fight to defend their independent professional status. *That is entirely different from whether socialization can be lawfully forced on them.* I might add that any other construction of the statute would raise the gravest questions.

I have great difficulty in following the Government's criticism of county and regional doctor groups who have set up their own local prepaid plans. They are but discharging their duty to their own local people, it seems to me.

Plaintiff's case was, at my request, argued fully at the end of the Government's testimony; and, having had the advantage of extensive pre-trial hearings and exhaustive briefs, I have not felt the need for further arguments.

Judgment of dismissal will at a later time be entered.

Dated at Portland, Oregon, this 28th day of September, 1950.

(Signed) CLAUDE MCCOLLOCH, *District Judge*

The highest yield of silent cancer of the lung will be found in men forty-five years of age and older.

Cancer Comment

SECOND MICHIGAN CANCER CONFERENCE

The Second Michigan Cancer Conference, held in Grand Rapids on October 18, 1950, drew an attendance of approximately 175 representatives of lay and professional organizations throughout Michigan. The Conference was sponsored by the Cancer Control Committee, Michigan State Medical Society, the Michigan Department of Health and the Michigan Division, American Cancer Society. Four papers were presented at the morning session, and a round-table discussion followed the luncheon.

A. E. Heustis, M.D., Commissioner of Health, reviewed the cancer problem in Michigan as it has developed over the years. There are still wide gaps in what we know about controlling cancer and what is being done in that field. Nothing can take the place of the careful physical examination as a case-finding procedure. New diagnostic tests have not yet been found reliable for general use.

Dr. Heustis stated that periodic physical examinations are helping to find more early cancer, as is the Hillsdale Plan, whereby every doctor's office is a detection center. This plan has been accepted, in principle, by about twenty Michigan counties and by an increasing number of state and local medical organizations throughout the country. He pleaded for acceptance of cancer reporting as an essential part of better cancer control, and for better local organization and co-ordination of cancer activities. Professional education is continuing through the bi-monthly distribution of the *Cancer Bulletin* to all physicians in the state. Increasing emphasis is being given to lay education, especially high school education.

Dr. Heustis paid a glowing and well-deserved tribute to the work of Dr. Norman F. Miller, chairman of the Cancer Control Committee, who resigned this year because of pressure of work in his new Maternity Unit in the University Hospital. Under Dr. Miller's leadership, Michigan has added another "first"—the Hillsdale Plan for routine examinations of easily accessible sites of cancer in patients willing to have the check-up, the examination being made in the office of the patient's own physician and at a nominal expense. The percentage of positive findings of unsuspected, early and *therefore curable* cancers has brought national acclaim of this very simple procedure.

C. D. Selby, M.D., lecturer on industrial health, School of Public Health, University of Michigan, in discussing industrial physical examinations as cancer case-finding procedures, said that because of the fine relationship existing between the industrial physician and employes many opportunities arose for finding cancer in early and curable stages. The time element in pre-employment examinations precludes cancer studies, but the frequent contacts with employes give many opportunities for examination, education and reference to family physicians for conditions—including cancer—that have no relation to the employment. Employe magazines are good educational media. The physical examination of executives now required in many industries offers additional opportunity for cancer case finding.

J. R. Heller, M.D., director, National Cancer Institute, Bethesda, Maryland, discussed progress in cancer research. He pointed out that from the many research programs now under way, many encouraging facts were developing. Research is being increasingly focused on the cell, especially its biochemistry. There are important chemical differences between normal and cancer tissue, especially in their enzyme content and use of carbohydrates.

Dr. Heller described a new technique for study of single cells in capillary tubes by means of the electronic microscope. Such control enables the effect of drugs on single cells to be observed and promises to aid materially in the studies on cell metabolism.

Adequate quantities of cancer tissue are now available from known genetic sources so that extensive laboratory studies can be carried out on the destructive action of many chemicals on cancer cells. None of the new therapeutic measures can yet replace surgery, x-rays and radium; and no new diagnostic agent can offer as much protection to the patient as careful physical examination, supplemented by biopsy when indicated. Some of these

(Continued on Page 1394)

"Stick-to-it-iveness is fine—

for everyone else...

"but take me—I just can't stick to my diet. I can't resist desserts. Oh, dear, this diet is getting me down!"

If she thinks it's getting her down what's it doing to physicians who have to listen to such explanations every day? This is especially true for the doctor who hasn't prescribed Efroxine Hydrochloride.

Efroxine makes it easier for most patients to reduce by depressing the appetite and elevating the mood. Efroxine offers a number of advantages over other sympathomimetic amines.

...It has a more rapid and longer-lasting effect with smaller dosage.

...It has little pressor effect in the recommended dosage range. This advantage is particularly valuable in the treatment of obesity.

...It is more likely to produce cerebral stimulation with relatively few side effects.

Efroxine Hydrochloride *Tablets and Elixir*

Maltbie Brand of Methamphetamine Hydrochloride

Maltbie Laboratories, Inc. Newark 1, New Jersey

Editorial Comment

PAY MORE, GET LESS

A pamphlet about President Truman's national health plan is now being distributed by the Democratic National Committee. It is attractively printed and undoubtedly rather expensive for nationwide distribution. The committee, however, probably figures the title "Better Medical Care Than You Can Afford" has vote-getting appeal.

All in all, it is an argument for compulsory health insurance on a national scale. There are few readers who are not familiar with the arguments for and against the program. To this date the American people and Congress have been far more impressed by the cons than the pros.

As usually is the case with Administration propaganda, there is a large measure of misinformation and misleading statements. For instance, try to logically explain the possibility of "better medical care than you can afford" with a program of "more medical education, more medical research, more hospitals and health centers, more local public health work and more health protection for babies and children."

These worthy objectives have been and are being met by the medical profession. And they can be attained in the future, if the experience in other countries is any criterion, on a far better scale at lower cost by the medical profession as it is now constituted, rather than under a program of socialized medicine which, by its very nature, would place doctor and patient alike under the thumb of a colossal and ever-expanding Federal bureau.

The cost of medical care and treatment under Federal health insurance could not be measured by the size of the doctor's bill or the hospital statement. The real cost would be hidden in general Federal taxation. Every family would pay far more for medical protection and, at the same time, be wound up in an inevitable amount of Government red tape.

Those who actually believe national compulsory health insurance would result in better protection at less cost somehow feel they will not be called upon to pay their share of a multibillion Federal program. They can't escape. They will be called upon to pay, one way or another.

It is no secret that millions under the national life insurance have been paid out of the Federal Treasury. This was not the original intention of Congress, but it has been and is being done. As a result refund dividends have been paid to policy holders.

Veterans and non-veterans alike know this money does not grow on trees. They are paying for it through income tax payroll deductions and other Federal taxes.

There is every reason to believe Federal health insurance would follow the same pattern. It would start out on a pay-as-you-go basis, and would wind up as part of a general social-welfare program, supported by frequent and costly raids on the Treasury.

The Democratic National Committee believes the idea of compulsory health insurance is good campaign material. It is no better than any socialistic appeal, any effort to bring under Federal control institutions which have grown and flourished in our traditional atmosphere of individual liberty and freedom.

It is our firm conviction that compulsory health insurance would result in lower medical standards and service at higher cost to the individual and progressive regimentation of the medical profession which would blight incentive and slow down the wheels of progress in research and scientific development.—Editorial, *Marquette Mining Journal*, October 18, 1950.

AS WE SEE IT

Just a Few Notes About "Stupidity"

Just in case you don't care much for the administration's "socialized medicine" plan—quite a few people don't—you should fully understand that (in one man's opinion) you're stupid and dangerous."

That's on the word of Mr. Oscar Ewing, who is the federal security administrator and—presumably—would be the man who would be responsible for your "cradle-to-the-grave" medical care, if the administration plan became law.

Mr. Ewing made a speech the other day, in which he lumped together under one label all the people who have the silly idea that they'd prefer to arrange for their medical care and pay for it

(Continued on Page 1384)

AS WE SEE IT

(Continued from Page 1382)

themselves—and the label he gave 'em was that above: "stupid and dangerous."

Of course, Mr. Ewing *did* declare that the plan isn't "socialized medicine" (which sounds like a stupid statement to us), but even at that, if it isn't "socialism," why use the tactics of socialism in promoting it?

By the "tactics of socialism" we mean the extreme expression of intolerance of any views other than his own which characterized Mr. Ewing's address. Intolerance has been a characteristic of every socialistic move in history—the grouping together of every one who thinks differently and "putting a brand" on him.

Not everyone agrees that the federal medicine program, would be good for America. And some very brilliant men are among those who do not agree.

Lump labels are dangerous business—because they are very likely to reveal stupidity on the part of the person voicing them.

Some very famed scientists, whose contributions to health and comfort are beyond estimation, are opposed to the administration's federal medicine plan.

Some famed liberal leaders, both in congress and out, are opposed to the plan.

Some noted sociologists, whose business is the improvement of mankind's lot, are opposed to it.

And a deuce of a lot of Joe, Jim, John and George Does, who still retain a measure of independence and prefer to paddle their own canoes rather than sucking at the breasts of a "benevolent government," are opposed to it.

Are all those men "stupid and dangerous?"

Apparently, in Mr. Ewing's opinion, they are. And their "stupidity and dangerousness" appears to lie in this: that they don't agree with Mr. Ewing and the administration.

Even as campaign propaganda, Mr. Ewing's statement seems stupid to us—stupid because it reveals to the public an intolerance of other men's views and a desire on the part of a paid "servant of the people" to ram his opinions down their throats, brooking no opposition.

That has no place in a government such as ours was intended to be—and when it has a place in the government, we'll then have the sort of regime we've been told we were fighting to avoid.

Presumably, as we said, Mr. Ewing would be the man who would administer the federal medicine program, if it became law.

Suppose you were sick but his people said you weren't—would you then be "stupid and dangerous" because you disagreed—and get no medical care?

Anyway, we'll take a few "stupid" steps and realign ourselves with the ranks of the "stupid and dangerous"—because we think it would be a tragedy for America and another step into the frauds and idiocies of socialism if the program ever were enacted.

One good thing, though, we see in Mr. Ewing's speech.

He has made very, very clear the greatest single reason we're opposed to the "socialized medicine" plan—it would of necessity require that great power be put into the hands of its administrators, who then would have the authority to brand other men "stupid and dangerous" and force their views on those men, through their control of the facilities for healing.

There are other reasons why we oppose the program (one of which is that we don't think it will work), but that's the greatest one.

Such power as that, we think, has no place in America—nor has any measure which would create it.—Editorial, *Fort Smith Times Record,* October 2, 1950.

MEDICINE BY COERCION?

Toward a Reign of Terror

Dr. Harry M. Hedge, president of the Illinois State Medical Society, reports that his office on Michigan Ave. was entered and his files rifled by snoopers who apparently wanted to examine his income tax records. The incident is alarming, especially since it parallels a similar invasion last year of the office of the American Medical Association.

The prowlers who rifled the files of Dr. Hedge were no ordinary burglars. Sneak thieves would have carried off valuable tools and office furnishings. The invaders apparently took nothing except a batch of clippings from *The Tribune* dealing with the recent demand by the FBI for the records of the medical society. Some of the clippings were of an editorial in which we said the investigation was an act of a political gestapo inspired by the opposition of medical men to Senator Lucas.

(Continued on Page 1386)

MEDICINE BY COERCION?

(Continued from Page 1384)

Evidently Mr. Truman's gestapo also is trying to get something on the officers of the medical society.

If the Treasury or Justice departments have good reason to suspect any citizen of wrong-doing, proper legal processes are available by which his records can be examined. The Constitution is explicit, however, in forbidding snooping expeditions. It says:

"The right of the people to be secure in their persons, houses, papers, and effects against unreasonable searches and seizures, shall not be violated, and no warrants shall issue but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched and the persons or things to be seized."

There is, of course, no such security in Russia, where any man's house can be searched at any time and where any man can be hustled off to a slave labor camp if he dares to express opposition to government policies.

Incidents are multiplying that we are moving in the Russian direction in spite of the Constitution. One phase of the movement seems to be designed to intimidate organizations which are seeking to influence public opinion by circulating books and tracts criticizing the New-Fair Deal hierarchy.

An organization called the Committee for Constitutional Government recently arranged to distribute copies of John T. Flynn's book, "The Road Ahead: America's Creeping Revolution." Through the committee, a small number of persons bought several thousand of these books. As a result, Edward A. Rumely, executive secretary of the committee, was hailed before Representative Buchanan's special house committee to investigate lobbying, which demanded the names of the book purchasers. Mr. Rumely refused, and was cited for contempt.

Why does the committee want these names? John T. Flynn answers the question in the first issue of the excellent new magazine, *The Freeman*. Says Mr. Flynn:

"With the names in hand, the invisible government in Washington can proceed to work on its campaign of intimidation. The government's instruments of harassment are numerous, and where the government's powers stop, its various privately financed allies can take up the work.

(Continued on Page 1388)

MEDICINE BY COERCION?

(Continued from Page 1386)

"Not long ago such a group came into possession of the names of the contributors to another organization. Presently the agent of one of these groups called on one of the largest contributors to this organization. He coolly informed this gentleman that upon investigation he knew that almost half of the customers of his company belonged to elements in the population who could be stimulated to boycott his products if they knew he was contributing to the condemned organization."

Thus we have come to the point where no citizen can feel free to protest against the Washington powers, in spite of the Constitutional guarantees of freedom of speech and the press, the right to petition for a redress of grievances, and the right to be secure against unreasonable searches and seizures.

Circulate all the left wing propaganda that you like, but don't try to organize propaganda for the principles of the Constitution. If you do, the FBI may be at your door, or your office may be rifled, or your business may be boycotted.—Editorial, *Chicago Daily Tribune*, October 16, 1950.

World Medical Association

Five hundred medical leaders—representing twenty-eight nations of the world—gathered in New York, October 17-20, 1950, to discuss problems of the medical profession and to hear reports on medical progress.

The occasion was the fourth General Assembly of the World Medical Association, a voluntary organization of national medical associations in forty-one countries with a combined membership of nearly 500,000 physicians. More than 225 American doctors attended the meeting, the first W.M.A. General Assembly to be held in U. S.

Euthanasia (mercy killings), Nazi medical atrocities, the British National Health Service and other issues came up for discussion as well as the latest developments in endocrinology, gastroenterology, and other medical areas.

The W.M.A., which held its first meeting of the General Assembly in Paris, September, 1947, has as its aim the betterment of health throughout the world.

"The motivation of the World Medical Association is conspicuously free from political and nationalistic purposes," Dr. Louis Bauer of New York explained. Dr. Bauer serves as secretary-general of the W.M.A. at its New York headquarters and is also chairman of the board of trustees of the American Medical Association.

War in the Far East prevented some delegates from attending. Because visas had been frozen under the new Internal Security Act, at least ten delegates from Europe and South America failed to arrive.

Russia has never been represented in the W.M.A., but some of the countries now in the Soviet bloc have been. However, all but one have withdrawn, and that one, Bulgaria, did not send a delegate to the recent meeting.

One of the highlights of the assembly was the inauguration at the opening session on October 17 of Dr. Elmer L. Henderson of Louisville, Kentucky, as president of the W.M.A. Dr. Henderson was installed as president of the American Medical Association in June of this year and thus becomes the first physician ever to lead simultaneously the two largest medical associations in the world.

At the inauguration, Dr. Henderson said "physicians by their thinking, spirit and effort can set an example for governments, diplomats and people everywhere to preserve the peace." Noting that the W.M.A. is uniting the medical profession of the world, he declared, "continued increased co-operation of that kind is one of the necessary ingredients for building a better world." He called upon the doctors of the world to "demonstrate convincingly that international co-operation is a workable reality."

Dr. Charles Hill of London, retiring president, was unable to attend the medical meeting. Conflicting duties in parliament prevented his coming. He sent a message to delegates expressing faith in the accomplishments of the W.M.A.

Dr. Hill, however, expressed serious dissatisfaction with the present British National Health Service. He wrote that the general practitioner in England is losing both patients and prestige. If it becomes clear that no prospect for satisfactory settlement is in sight, "preparations should be made for a withdrawal of general practitioners from the National Health Service," Dr. Hill asserted.

General policy and medical ethics sessions of the General Assembly drew the largest attendance. At one spirited gathering, W.M.A. delegates voted "to condemn the practice of euthanasia under all circumstances" as "contrary to the public interest and to medical principles as well as to natural and civil rights."

Dr. S. G. Sen of India, and Dr. E. A. Gregg of Great Britain, fought a losing battle in favor of "mercy death with the consent of the patient and the state to bring an end to intolerable suffering." They argued many doctors have used drugs to speed the death of patients suffering from incurable diseases.

Delegates from Ireland, France and the U. S. were strongly opposed. Dr. Marcel Poumailloux of France, declared approval of euthanasia would "open the door to all possible crimes and criminal practices."

W.M.A. delegates voted to authorize the Council, the executive body, to consider any applications of doctors of Western Germany and Japan to membership despite the protests of two Israeli physicians, Dr. Emil Adler and Dr. S. G. Zondek.

The Israeli delegates protested that many doctors in Germany had been involved in and had even taken the initiative in such inhuman experiments as forced sterilization and vivisection of humans.

The charges of "crimes against humanity" were generally admitted by doctors of West Germany who declared: "We hereby solemnly give our promise through the World Medical Association to the medical profession through the world never again to participate in or to permit such a betrayal of medicine." The German physicians promised expulsion of members personally guilty of crimes referred to and those not willing to "maintain a high standard of professional behavior in the future."

The decision was thirty-three to three in favor of referring action to the Council. Dr. Adler said he did not object to the organization having relations with German physicians, but that there should be a "probation time" before admission to membership.

The assembly adopted another resolution disapproving attempts "by various governments to control the traditional freedom of science by dictating judgments on such biological and medical questions as genetics anthropology and even physiology to serve political ends." References to Soviet Russia and Nazi Germany as the governments in question were deleted.

Fraudulent and misleading drug advertisements were also criticized and delegates were advised to warn the public against new discoveries not fully tested.

At scientific sessions, doctors heard the latest advances

(Continued on Page 1392)

Announcement . . .

UHLEMANN OPTICAL COMPANY OF MICHIGAN

has become

SINCE 1919 the personnel of this organization, under the Uhlemann name, has had the privilege of serving an ever growing number of Michigan physicians in the filling of optical prescriptions.

TODAY, as the Ion Optical Company, all the time-tested skills and craftsmanship acquired through 31 years of experience are still at your command.

A Pledge. In the future, as in the past, we promise to maintain the highest standards of quality workmanship and service, to operate ethically, and to guarantee the satisfaction of you and your patients.

Ion Optical Company

28 West Adams Ave., Detroit 31, Mich., Phone Woodward 2-7229

BRANCHES: *In Detroit* • 666 Fisher Building • 1118 Maccabees Building
123 W. Allegan Street, Lansing • 308 Federal Street, Saginaw

(Continued from Page 1390)

in endocrinology, gastroenterology and in therapeutic uses of blood and blood derivatives.

Dr. Hans Selye of the University of Montreal, Quebec, told delegates his years of animal and clinical experiments suggested that the pituitary-adrenal glands were like balance wheels of life.

Studies reveal, he said, that these glands enable the body to adapt itself to all types of stresses including those caused by such baffling diseases as high blood pressure, kidney and blood vessel diseases, rheumatic diseases and others.

"We think derailments of the adaptive mechanism are the principal factors in production of certain maladies," Dr. Selye stated. "Worry may even weaken the pituitary-adrenal gland factories which produce ACTH and cortisone," new defenses against arthritis and other degenerative diseases.

Dr. Albert F. R. Andresen of Flushing Hospital, Brooklyn, N. Y., reviewed diseases of the stomach and intestines, declaring that "most medications for ulcer are useless," and that so-called hyperacidity plays no important part in causing ulcer and requires no treatment.

"The treatment of uncomplicated ulcer in view of the fact that it is known to heal spontaneously should consist simply of a bland, well-balanced diet, a little high in protein values, with frequent feedings," said Dr. Andresen.

Special treatment, even operative techniques, are sometimes necessary, however, if perforations or persistent hemorrhages are evidenced, he added.

The director of blood banks for the National Red Cross, Dr. L. K. Diamond of Boston, told the medical men that the world's blood needs have greatly increased in the last few years because of the need for blood stockpiles for defense. He estimated that the U. S. would need from four to five million pints of blood per year to meet civilian needs plus an undertermined amount for military and civilian stockpile in case of emergency.

The American Medical Association was host to delegates at a dinner on October 19. At that time Dr. Roger I. Lee of Boston, past president of the AMA, told the assembly that medicine, unlike most professions, does not patent its products and procedures but makes them available to the public.

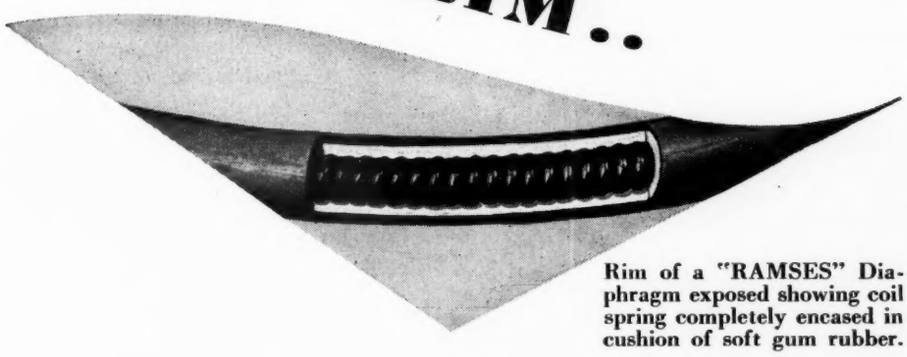
"Patents have enriched many inventors and some scientists outside the medical field," Dr. Lee said. "I wonder what the public reaction would be if a valuable remedy were cornered and exploited by a patent with the result that people died for want of the remedy?"

On October 20, delegates visited West Point where Major General Bryant E. Moore, superintendent of the U. S. Military Academy, told visitors that the medical profession could prove to be a forceful factor in promoting world peace.

"With each year has come a deeper realization that members of the medical profession are the true international diplomats of peace," General Moore said at a luncheon meeting. "Your influence is based upon the

(Continued on Page 1394)

COMFORT IN A RIM..



Rim of a "RAMSES" Diaphragm exposed showing coil spring completely encased in cushion of soft gum rubber.

A coil spring with the necessary tension to hold it firmly against the vaginal walls can produce discomfort unless it is properly cushioned. Examine the rim of the "RAMSES"* Diaphragm and you will find that the coil spring is encased in soft rubber tubing, which acts as a protective cushion. This construction is patented and available only in the "RAMSES" Flexible Cushioned Diaphragm.

PROTECTION IN A DOME..

The "RAMSES" Flexible Cushioned Diaphragm is accepted by the Council on Physical Medicine and Rehabilitation of the American Medical Association.

A diaphragm dome must not only occlude the cervix—it must have a reasonably long life. The exclusive process used in manufacturing the dome of the "RAMSES" Diaphragm from pure gum rubber produces velvet smoothness, plus flexibility and long life.

A comparison will quickly reveal the advantages of supplying the patient with the patented "RAMSES" Flexible Cushioned Diaphragm.

"RAMSES" Diaphragms are available in sizes ranging from 50 to 95 millimeters in gradations of 5 millimeters.

A MARK OF Ramses DEPENDABILITY

gynecological division

Julius Schmid, Inc.

423 West 55th Street, New York 19, N. Y.

quality first since 1883

***The word "RAMSES" is a registered trademark of Julius Schmid, Inc.**

(Continued from Page 1392)

esteem in which peoples of all countries hold the profession of medical sciences. It is not improbable that a road to permanent peace will be found through your efforts to expand the horizons of medicine."

At the concluding session of the assembly Dr. Dag Knutson of Djursholm, Sweden, was unanimously chosen as president-elect of the organization. He will take office at the fifth General Assembly of the W.M.A. to be held in Stockholm, Sweden, September 15-20, 1951. Delegates voted to hold the 1952 meeting in Athens, Greece.

Dr. Knutson has been president of the Swedish Medical Association since 1946. A specialist in internal disease and head of the University Policlinic for Internal Disease at Karolinska Sjukhuset, Stockholm, Dr. Knutson has served on the Council, the executive body of the W.M.A., since 1947.

Dr. Otto Leuch of Switzerland, was reelected treasurer and the following council members were reelected: Dr. J. A. Bustamante, Cuba; Dr. S. C. Sen, India; Dr. R. L. Sensenich of South Bend, Ind., and Dr. L. Garcia-Tornel of Spain.

A Conference of Medical Editors of the World was held on October 21, with Dr. Morris Fishbein of Chicago, editor of the *W.M.A. Bulletin,* as chairman.

CANCER COMMENT

(Continued from Page 1380)

new agents give promise of becoming valuable tools after they have been further refined. At present they are all in the laboratory, or experimental stage.

Professor Paul D. Bagwell, of Michigan State College, East Lansing, emphasized the importance of the individual's responsibility for cancer control. He pointed out the many facilities, including the Hillsdale Plan, for the diagnosis and treatment of cancer in Michigan but stated that their value depended on the willingness of the public to use them. Ignorance and carelessness were two factors that prevented acceptance of these facilities. Both factors could be routed by a more intensive and extensive lay education program.

Professor Bagwell urged his audience to replace their unfounded fears of cancer with known facts and thus avoid the fatal delay that so often dooms the cancer patient to an untimely death.

Following adjournment of the Conference, the Cancer Control Committee met and agreed to hold another conference in 1951 under the same auspices. A sub-committee was appointed to plan details of the program.

Military Medicine

NEW TYPE OF ARMY MEDICAL COMPANY TO SEE SERVICE IN KOREA

A preventive medicine unit of company size, first of several of its kind now being organized by the Army Medical Service, has arrived in the Far East Command for duty in Korea, Major General R. W. Bliss, the Army Surgeon General, announced November 6, 1950.

Successor to the malaria survey and malaria control detachments which played key roles in the Southwest Pacific and elsewhere during World War II, the new company has functions beyond the scope of previous units of this type. In addition to malaria control and survey, the units will be responsible for inspections of field sanitary conditions and control of insect-borne, water-borne and other diseases. When acting in support of combat troops, these companies will operate as far forward as necessary to accomplish their mission.

The new preventive medicine companies are composed of six officers, one warrant officer and fifty-nine enlisted men. Units are being organized at Brooke Army Medical Center, Fort Sam Houston, Texas. Officer personnel are qualified entomologists or sanitary engineers, and the enlisted men have had training in one or more phases of preventive medicine.

The preventive medicine company is composed of a headquarters section, to accomplish command and administrative work, and a preventive medicine service subdivided into a hygiene and sanitation section, survey section and three control sections.

The hygiene and sanitation section investigates water points, waste disposal, troop shelter, bathing and laundering facilities, mess sanitation, contamination of food or water and adequacy of clothing. The survey section inspects sanitary discipline in other units, determines the incidence and distribution of insect-borne and similar diseases and checks on the origin of cases of these diseases admitted to hospitals in its area. The control section furnishes technical supervision for work details engaged in sanitary control measures, and also conducts on-the-job training of soldiers in insect and rodent control measures, and recommends corrective measures for other units.

TRIPLER HOSPITAL, HONOLULU

High praise for the Army's newest and best-equipped hospital, Tripler Army Hospital, near Honolulu, Hawaii, was given by Major General R. W. Bliss, the Surgeon General.

In meeting one of the Nation's greatest responsibilities to the men who have borne the battle in Korea, Tripler Army Hospital has played a most important part.

Aside from caring for its own regular patient load, which recently occupied over 900 beds, Tripler has given an average of two days of rest, comfort, and necessary medical attention to over 5,000 patients evacuated from Korea and Japan to the United States. General Bliss feels that without this vital link in the chain of evacuation, many types of patients would have to remain because their condition would not permit a nonstop flight from the Far East.

Tripler Army Hospital, little more than two years old, is jointly staffed by Army, Navy and Air medical personnel and cares for patients from all three military services as well as for Veterans and Public Health Service beneficiaries. Universally considered outstanding in hospital architecture, Tripler incorporates many features designed to keep the hospital abreast of medical developments for many years to come. Among these features are:

Recovery ward, in which every bed has available an oxygen and a suction outlet for immediate use in any emergency; specially-partitioned wards, designed and located in accordance with the needs of each service; a special shelter and large dayroom at the end of each ward, which provide space for recreation during normal times and a means of expanding the ward in case of necessity; a pneumatic tube system connecting all wards, clinics, and departments of the hospital, which allow necessary papers to be sent rapidly from any part of the hospital to any other; and a neuropsychiatric section, providing indoor and outdoor recreational space, dining rooms, and therapeutic facilities without the atmosphere of confinement common to most hospitals that care for mentally and emotionally disturbed patients.

Planned to overcome the serious lack of adequate military medical facilities in the mid-Pacific area demonstrated during the second World War, Tripler Army Hospital was authorized by Congress in June, 1944, and opened its doors in July, 1948.

907 REGISTERED IN MEDICAL DRAFT

State Total Includes 622 Doctors, 190 Dentists

Complete returns from local draft boards show 907 medical doctors, dentists and veterinarians were registered in Michigan October 16 under new provisions of national selective service regulations.

Col. Glenn B. Arnold, state draft director, said the list includes 622 medical doctors, 190 dentists, and ninety-five veterinarians.

The special draft registration embraced doctors under fifty years of age who were trained in army or navy specialized programs and those deferred from military service during World War II to complete medical education or those who served less than twenty-one months in actual duty after special training.—*State Journal*, Lansing, October 26, 1950.

The average patient waits three months after the onset of symptoms of lung cancer before seeking medical advice.

The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

VOLUME 49 DECEMBER, 1950 NUMBER 12

Cardiac Research

By F. Janney Smith, M.D.

Detroit, Michigan

THE RATE of progress of cardiac research has been recently accelerated due to the stimulation resulting from the knowledge that heart and blood vessel diseases now rank as the first cause of death, greater than the next five causes combined, including cancer. The chief contributing cause to this mounting prominence of degenerative cardiovascular disease is a beneficent one: the conquering of infectious diseases. More and more people are surviving or avoiding infections only to succumb at a later age to degenerative diseases. These facts have given rise to pressure from the life insurance companies to encourage research in cardiovascular diseases through the formation of the Life Insurance Medical Research Fund. Also, the American Heart Association through its own funds and those of its affiliates, as well as the National Heart Institute, have made funds available to qualified workers in the field of cardiovascular research, giving further aid and stimulation to investigators in this field.

To one who has spent more than half his life in the practice of cardiology, great progress through cardiovascular research has already been made.

Rheumatic fever's ravages have been stayed somewhat by improvement in living standards, and by Rheumatic Fever Control programs such as we have in Michigan. Recurrences of rheumatic fever have been prevented by the prophylactic administration of sulfonamide drugs and by other antibiotics that control and prevent recurrent streptococcal infection. ACTH and Cortisone have occasionally proved to be life saving in the more malignant cases of acute rheumatic carditis.

Congestive cardiac failure has been more successfully treated by better understanding of the electrolyte problem, better digitalis preparations and diuretics.

Subacute bacterial endocarditis can now be cured by antibiotics in eighty per cent of cases.

The crippling effects of many congenital cardiac defects have been alleviated by the dramatic intervention of the cardiac surgeon with increasing success. Cardiac catheterization and related physiological studies have aided greatly in diagnosis and selection of suitable cases for operation.

Mitral stenosis is being attacked by commissurotomy with promising results.

In the field of coronary artery disease the use of anticoagulants in coronary thrombosis has significantly reduced the occurrence of thromboembolic episodes and reduced mortality.

The underlying atherosclerotic process in the coronary vessels has been shown to be related to cholesterol metabolism. Recent work by Gofman has indicated that by means of the ultra-centrifuge it may be possible to identify bloods of these people who are likely to develop arteriosclerosis by recognizing a preponderance of certain large cholesterol molecules which are capable of being deposited in the arterial walls. Best measures to be taken in the treatment of such individuals are not completely clear other than the use of low cholesterol diets, but the whole subject is under intensive study.

The addition of penicillin to our armamentarium for the treatment of syphilis has greatly reduced the number of people with cardiovascular syphilis.

Hypertension in its more serious aspects has been favorably influenced by sodium poor diets, rice diet, by dorso-lumbar sympathectomy, in some

cases by hyperpyrexia, and to a lesser extent by various drugs as well as protective living programs.

Advances in electrocardiography have been many and have contributed to more accurate localizing and defining of the extent of myocardial infarcts, as well as supplying diagnostic information applicable to many other conditions.

Industry has initiated periodic health examinations among both executives and employes thus permitting earlier detection of cardiovascular disease.

Research requires first of all qualified personnel. It next needs the inquiring mind and sufficient drive to overcome initial inertia. And it must have proper equipment from the point of view of materials and technical help. Many of these last named items are expensive. While great discoveries are not all bought with money, in the past many good research projects have "withered on the vine" for lack of funds. The isolated establishment of various small proven points may later be consolidated into truths of great medical importance. At present an organized approach to research seems justifiable.

The Michigan Heart Association has endeavored to exercise care in the choice of qualified workers and in allotting its funds for research projects. It is the purpose of this editorial to inform the members of the medical profession in Michigan as to the type of work now in progress making use of these allotments.

Reports of Research Projects Supported by the Michigan Heart Association

Gordon B. Myers, M.D., Wayne University, Detroit, has been carrying on a varied research program jointly supported by the Michigan Heart Association and the National Heart Institute. The following studies were completed during the past year and are being prepared for publication: A paper, "Treatment of Congestive Heart Failure with a Fifty Milligram Sodium Diet—Metabolic and Clinical Study," was read at the meeting of the American Heart Association in June, 1950. A study titled "Fluid and Electrolyte Balance in the Management of Acute Renal Insufficiency" was presented at the Eastern Meeting of the American Federation for Clinical Research. A manuscript on "The Quantitative Estimation of Calcium in Human Plasma by Flame Spectrophotometry" has been submitted to the *American Journal of Clinical Pathology.*

Several other studies have been submitted for the fall meetings of either the Central Society for Clinical Research or the American Federation for Clinical Research. These include:

(a) The water and electrolyte content of cardiac and skeletal muscle; comparative values in normal hearts, in digitalized and undigitalized hypertrophied hearts, in congestive failure and in myocardial infarction. Specimens were secured at autopsy from five standard sites in the heart from the pectoralis muscle. Analyses were made for water, Na, K, Cl, Ca, Mg, Fe, Cu and P in forty-one cases, and for water, Na, K in twenty-four aditional cases.

(b) A new method for the determination of protein-bound iodine in plasma or serum. This method differs in several important respects from all previous methods and is more rapid and circumvents certain sources of error inherent in present methods.

(c) Studies of renal function in Weil's disease.

During the coming year the following additional investigations are planned:

(a) A study of water, Na, K, Cl and N balance during development of congestive failure and during recovery under various therapeutic regimens. This represents a continuation and elaboration of the work reported at the American Heart Association meeting in June.

(b) A study of water, Na, K, Cl and N balance in acute glomerulonephritis and in the nephrotic syndrome. This is also a continuation of work in progress. The practical nurses and technicians supported by the Michigan Heart Association grant for 1950-51 have an essential role in both of the foregoing projects.

(c) The use of catheterization techniques for selection of cases of mitral stenosis for commissurotomy and for evaluation of operative results.

(d) The employment of similar techniques for an investigation of the effects of vasodilator drugs on pulmonary hemodynamics in chronic cor pulmonale. These studies will be carried by Dr. Harper K. Hellems, Assistant Professor of Medicine, assisted by Dr. Henry Uhl, Research Fellow under the Michigan Heart Association.

Conrad Lam, M.D., Henry Ford Hospital, Detroit. In the surgical laboratory of the Henry Ford Hospital, Dr. Conrad Lam and his associates have been able to transplant the aortic valves of donor animals into the descending aortas of other animals, and these valves have been proved to be functioning months after the operation. The techniques used in these experiments were subsequently applied in a human case in which a large fusiform aneurism of the thoracic aorta was replaced by a homograft.

Dr. Lam and his associate, Dr. Munnell, have investigated the value of the use of modern elec-

tronic apparatus for measuring physiologic pressures during intracardiac operations for valvular disease. In twelve operations on the mitral valve, such determinations were found to be of definite prognostic significance. Interesting observations were also made during the Brock operation for pure valvular stenosis of the pulmonary artery.

Robert F. Ziegler, M.D., Henry Ford Hospital, Detroit, has been making a study of "The Influence of the Intraventricular Conduction on the Electrocardiographic Pattern of Ventricular Hypertrophy." This project has been delayed for lack of a qualified assistant. Therefore, it was thought advisable to return the funds allotted for this research to the Michigan Heart Association. The work will be carried on at a slower pace, although a certain amount of experimental surgery will have to be incorporated before it can be completed. The majority of the work at present will be confined to accurate measurement of clinical records now available. This study should yield information of great practical use in the diagnosis of single chamber enlargement.

James L. Wilson, M.D., University of Michigan, Ann Arbor, is obtaining complete diagnostic and pertinent metabolic studies on children with congenital heart disease in an attempt to work out simpler and more practical methods of diagnosis. Psychometric and personality studies before and after operation are planned for the future. Dr. Stern is actively engaged in this work and a technician is at work on the chemical and metabolic determinations.

Franklin D. Johnston, M.D., University of Michigan, Ann Arbor, with the help of a research fellow is studying particularly the areas of electrocardiographic deflections and the ventricular gradient by means of a newly developed electronic integrator and is also conducting a study of low frequency vibrations produced by the heart.

Sibley W. Hoobler, M.D., University of Michigan, Ann Arbor, beginning on July 1, has assembled an artificial kidney of the type described by Leonard and Skeggs. Present efforts are being directed as follows:

(a) Application of the artificial kidney to patients with uremia and hypertension.

(b) Demonstration that a small molecular pressor substance (arterenol or norepinephrine) will pass through the cellophane filter and be detected in ultrafiltrate from the kidney.

(c) Investigation of certain procedures to concentrate and increase the yield of norepinephrine from the ultrafiltrate.

(d) To establish the best and most suitable method for assay of pressor activity of unknown ultrafiltrates.

David F. Bohr, M.D., University of Michigan, Ann Arbor, is working on several projects.

(a) The role of neurogenic and humoral factors in determining the vascular resistance of the salivary gland in sustained arterial hypertension. The technique of isolation of the arterial supply and venous drainage of the submaxillary gland of the dog has been refined. Preliminary observations have been made demonstrating an increase in the peripheral vascular resistance of the gland in response to the arterial administration of both renin and hypertension.

(b) Diagnostic and prognostic significance of the brachial-to-digital systolic pressure gradients in hypertension. Two separate types of data are being collected for this project: (1) An attempt is being made to determine pressure gradients on all patients with elevated blood pressures who are patients in the University Hospital. From this information it is hoped to have data which will enable one to determine whether the various types of hypertension may be differentiated on the basis of variations in brachial-to-digital systolic pressure gradients. (2) Selected patients will be studied through long-term courses of treatment in order to determine if data is of prognostic value.

(c) Assay of blood ultrafiltrates for pressor and antidiuretic activity. This study is being carried out in conjunction with Dr. Sibley Hoobler and depends both on the production of the ultrafiltrates in the artificial kidney and on the refinement of our salivary gland technique for assay of pressor substance.

(d) The role of smooth muscle of the heart in governing cardiac output. At the time this project was proposed to the Michigan Heart Association two types of data were available indicating that tonus change, and hence the smooth muscle activity of the turtle heart, played an important role in determining cardiac output. First, spontaneous rhythmic increases in tonus of the turtle heart are accompanied by decreased cardiac output. Next, a substance that reduces the tonus of smooth muscle causes a marked increase in cardiac output in the turtle heart. Additional indirect evidence has now been obtained that smooth muscle plays an important role in the cardiac output in the lower vertebrates. In the snake heart, which displays much less spontaneous rhythmic, tonic activity than the turtle heart, the administration of hesperidin methyl chalcone, which has a specific relaxing effect on smooth muscle, has a much less prominent effect on cardiac output. The effect of smooth muscle activity on the cardiac output in the mammalian heart remains to be evaluated.

Cameron Haight, M.D., University of Michigan, Ann Arbor, together with Dr. Cowley, is working on an improved method for determination of coronary blood flow which is to be applied in work aimed at improving surgical means collateral circulation from extra-coronary sources. This should aid in alleviation of angina pectoris.

John C. Bielawski, M.D., Detroit, has been employed by the Michigan heart association to direct its section on Occupational Cardiology as an expression of the desire of the Association to be of help in the employment problem posed by patients with heart disease. Initially, he made an extended field trip, contacting the leaders in this work in various sections of the country and set up his section to provide consultation service to industrial physicians in the problems raised by employment of cardiacs. Under the direction of E. A. Irvin, M.D., Medical Director of the Cadillac Motor Car Division, General Motors Corporation, he spent a preliminary three months in actual in-plant service. With this background consultation service has been rendered to ten different industries in Detroit through their industrial physicians, and interviews have been had with numbers of other people interested in industrial health and hygiene. Dr. Bielawski has written an important paper on "Employment Problems Facing the Cardiac Patients," which was published in December, 1949, in THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY. This article reached virtually every physician in Michigan and reprints were requested widely from various groups outside the state, including a number of other Heart Associations. The paper also was read before a large number of medical meetings and interested groups.

Several other projects have been carried on such as the cardiac survey program, detailed in another article, "An Approach to the Study of Cardiac Disease in Industry," stressing techniques of discovering disease states in preclinical phases in order that early correction may prevent disability. This preventive medical viewpoint has resulted in chest x-ray screening at pre-employment and periodic industrial examinations. This included a study of the usefulness of the electrocardiogram. Utilizing the men of the Cadillac Motor Car Division, a total of six hundred thirty electrocardiograms were done as part of a routine examination. Thirty-eight electrocardiograms were abnormal. Of these abnormal electrocardiograms only thirteen patients were aware of heart disease. Twenty-five patients had no knowledge of heart disease.

To extend the range of techniques studied, a Multiphasic screening technique is now being planned, utilizing a short history, routine industrial examination, seventy millimeter photofluorogram of the chest, electrocardiogram, and urinalysis.

Another was the cardiac housewife project. The possibility of time and motion studies applied to the work in the home is of great value to housewives with limited physical reserve. The technique in saving steps and effort for the housewife disabled by heart disease was first observed on the New York field trip. Inquiry disclosed an expert in Detroit, Mrs. Sanderson, chairman of the Department of Home Economics, Wayne University.

With her help it was decided to study closely one cardiac housewife to see whether a program emphasizing change made at a minimum cost would be of benefit. The work savings effected and the utilization of pictures, lantern slides and charts to demonstrate the technique, led to its adoption as part of the program of the Michigan Heart Association on March 9, 1950. More cases have been carefully studied since. Arrangements are being made to ask Dr. Irma Gross of Michigan State College to extend the problem to the rural housewife. A merging of this cardiac housewife program with the industrial program resulted in changing the name of the section to "Occupational Cardiology." It is hoped that a positive approach to cardiac disease emphasizing remaining ability rather than disability has been helpful in enabling cardiac patients to remain useful, productive members of society.

F. Janney Smith, M.D., Henry Ford Hospital, Detroit, is concerned with observing the clinical use of anticoagulants, a study jointly supported by the Michigan Heart Association and the American Heart Association. This is being carried on as part of Dr. Irving S. Wright's Committee on Anticoagulants for the American Heart Association. So far the work has consisted of an alternate case study in myocardial infarction, comparing heparin and discumarol with paritol and tromexan. Paritol is a relatively new, synthetic heparinoid substance for parenteral use and has proved to be quite as satisfactory as heparin. It will be much less costly. It has been used in nearly fifty patients.

Tromexan, a synthetic coumarin for oral use, has a considerably more rapid action than dicumarol and also a more rapid excretion. Tromexan has been used in eighty patients. It is quite satisfactory in its anticoagulant effect, and it is attended by fewer hemorrhagic complications than dicumarol. The results of these studies are being compiled statistically with those of four other members of the Committee on Anticoagulants for the American Heart Association.

J. A. Johnston, M.D., Henry Ford Hospital, Detroit, has been engaged in the determination of the effect of ACTH on the storage of nitrogen and calcium in the growing child by the balance technique. This was felt to be important because any desirable effects need to be weighed against adverse effects on growth. It has already been shown that one immediate effect of ACTH administration is a loss of nitrogen and calcium.

Ten patients are in the process of being studied or have had studies completed. Six of these had acute rheumatic fever and four had rheumatoid arthritis. The original observations would seem to be confirmed. However, the initial negative balances promptly revert to strongly positive ones —in the case of nitrogen—on withdrawal of ACTH. Even when ACTH is continued, positive nitrogen balances are possible if food intake is increased. It is too early for final conclusions, but the impression has been gained that a child in his initial attack is benefited almost miraculously by ACTH without any adverse effects on his total metabolism. The child with a well-established valvular defect does poorly. A much longer follow-up study will be necessary before any dogmatic statements may be made.

Paul V. Woolley, M.D., Children's Hospital of Michigan, Detroit, is directing research in rheumatic fever, number one cause of death in the years five to twenty in Michigan. Dr. Woolley's project concerns the use of ACTH and Cortisone in the following categories: (a) Fulminating instances of acute rheumatic fever, (b) Chronic rheumatic fever with evidence of continuing activity, (c) Instances of early rheumatic carditis, non-fulminating, (d) Acute cardiovascular failure including rheumatic, hemorrhagic nephritis, disseminated lupus erythematosus, and meningococcemia.

E. H. Watson, University of Michigan, Ann Arbor, is working on a project for the study of the effect of ACTH and Cortisone on the response of patients with severe rheumatic fever and rheumatic heart disease.

Noyes L. Avery, M.D., Blodgett Memorial Hospital, Grand Rapids, is observing the effect of ACTH and Cortisone upon two classes of rheumatic fever: (1) initial attacks in patients without previous history of rheumatism or heart disease, and (2) those dangerously ill with rheumatic fever.

Ben E. Goodrich, M.D., Henry Ford Hospital, Detroit, together with two associates is engaged in observing group differences in the frequency of thromboembolic complications. Cardiac, diabetic, tuberculous, and orthopedic patients are being studied by a modification of the Allen protamine titration procedure, which was originally divised to detect heparinemia. It had been previously a useful test in patients with a bleeding tendency.

By the use of siliconized glassware, waxed cork stoppers, and half the quantity of blood originally advised the test has proved consistent in revealing physiological variations in "heparin-like" substances. Results in cardiac, diabetic, tuberculous and orthopedic patients agree with and suggest an explanation for the group differences in frequency of thromboembolic complications. The data accumulated establishes the test as a dependable means of obtaining unique and valuable information.

The study continues to explore the metabolic, pathologic, and mechanical factors which are related to variations in thrombotic tendencies. The completed report will appear in the program of the Central Society for Clinical Research in November, 1950.

The Rheumatic Fever Control Program of the Michigan State Medical Society is aimed at the control and eradication of rheumatic heart disease in Michigan. Consultation and diagnostic centers are maintained in Detroit, Ann Arbor, Jackson, Lansing, Kalamazoo, Grand Rapids, Traverse City, Pontiac, Saginaw, Bay City and Marquette.

MSMS

It is possible to demonstrate a lesion in the lung roentgenographically long before the patient has any symptoms or anything that would lead him to consult a physician for treatment of a pulmonary condition.

Diagnosis of Rheumatic Heart Disease

Criteria and Procedures

By Hugh McCulloch, M.D.
Chicago, Illinois

THE DIAGNOSIS of rheumatic fever and rheumatic heart diseases remains a complex and difficult problem. The recent surge of interest in the disease has accentuated the problem because public health surveys and case finding programs have been carried out in many places to determine the incidence of the disease in a locality, the nature and variation of the disease in that locality and the location or some other epidemiologic characteristics. The first requirement, therefore, has been criteria of diagnosis and procedures to establish criteria. The place of rheumatic fever in the overall program of school health services has focussed attention also on the need of accurate means for identifying rheumatic subjects. Greater attention has been directed also toward recognizing cases in early stages in order to bring them under control and to prevent cardiac damage. This phase of the problem has required that cases of rheumatic fever be recognized which do not present characteristic clinical attacks and when the diagnosis is relatively hard. In any phase of the problem, for which the diagnosis is a part, accuracy becomes important so that case incidence can be estimated correctly and so that individuals may be labeled correctly as rheumatic subjects. Otherwise cases are missed and, what may be even more serious, individuals be needlessly subjected to treatment programs, disturbing and costly to patient, the family and to the community. It is the purpose of this paper to set forth what constitutes the rheumatic status, some of the criteria of diagnosis, and how these criteria can be subject to interpretation, and to discuss some of the diagnostic procedures and how they can be applied.

Rheumatic fever is a recurrent disease with attacks following in rapid succession or spread apart by long periods of remission, maybe years apart, or the disease can produce long chronic illness, waxing and waning in severity, but persistently present for months and even years with no period of remission. All diagnostic criteria apply equally to the recognition of the start of an attack, the degree of activity at any stage and to the end of an attack and disappearance of activity. They serve to measure the progress of the disease as well as to diagnose its presence.

Rheumatic fever and rheumatic heart disease are intimately related, and any and every attack of rheumatic fever, no matter what the manifestations of the attack may be, produce some pathologic change or alteration in cardiac structure but in diagnostic studies and procedures this relationship may be overlooked or minimized to a point of danger. The principal interest often is centered on the heart disease as in the case when physical examinations alone are used in case finding. The presence of evidence of cardiac damage then is made the main point of recognition, and no attempt is made to identify rheumatic fever or to learn about past attacks. If heart disease is the only recorded finding, many cases of rheumatic fever will be missed. When the interest is centered on rheumatic fever, many doubtful cases are included as positive from fear of missing cases that may result in heart disease later.

The etiologic relationship between rheumatic fever and streptococcal infection has been studied for a long time and the phase reaction of a rheumatic subject to infection is clear. The relationship is accepted at present as a tissue hypersensitivity phenomenon, though the mechanism is not demonstrated. Diagnostic procedures and criteria of activity of rheumatic fever may be confused with those set up for the recognition of streptococcal infection. It is necessary to evaluate criteria and the results of every procedure in terms of these two separate but related processes. At the present time it can be proposed that not every attack of rheumatic fever is related to streptococcal infection. Other factors, such as hormone dysfunction, emotional stress, fatigue and shock may be the inciting agent preceding and provoking an attack.

When the manifestations of rheumatic fever rise to and above the threshold of clinical recognition, the situation becomes a simple one and the diagnosis is easy. The subject becomes ill and in one way or another seeks advice and help and comes within the range of medical care. Each patient will show, under these conditions, a constellation of major and minor expressions[5] of the disease to be recognized and interpreted by the observer. The

From La Rabida Jackson Park Sanitarium, Chicago, Illinois.
Presented at the First Annual Meeting of the Michigan State Heart Association, Detroit, March 11, 1950.

major expressions are polyarthritis, carditis and chorea. Each of these expressions in the constellation must be considered separately and subjected to analysis. Each may be due to conditions other than rheumatic fever and the distinction between them may require help and time and retrospect.

Polyarthritis

Polyarthritis is the expression of rheumatic fever from which the disease derives part of its name. The equally descriptive term of "inflammatory rheumatism" has almost passed out of use but may be recalled to help differentiate rheumatic fever from other forms of rheumatism. Polyarthritis is recognized by objective signs in joint areas of redness, heat, local tenderness and loss of function from pain. Polyarthralgia is not a correct term for there is more than pain. These signs are conspicuous in young adults and older children, in the order given. They are usually inconspicuous and indefinite in reverse of the order given in younger children, particularly during first attacks. The four signs can be identified objectively in the history and one or more of them must be identified in a present attack. Subjective complaints without identified signs should never be accepted as criteria. The signs are usually confined closely to joint areas, though nearby muscle and tendon tenderness may be associated. Smaller joints of fingers and toes, hands and feet, wrists and ankles, elbows and knees are usually affected with the signs migrating from one location to another within a few days. Multiple or single joints may be involved and the signs are always reversible with no residual changes. The relief of polyarthritis from salicylate exhibition is well known and may be a diagnostic procedure. Salicylate may be withheld from young children, unless the pain is severe, in order to follow the course of the polyarthritis.

Rheumatic fever may be difficult to distinguish from rheumatoid arthritis; indeed, according to present-day concepts, there may be no differentiation. The relationship of rheumatoid arthritis, dermatomyositis, lupus erythematosus, periarteritis nodosa and other such diseases of the reticuloendothelial and collagenous tissues becomes closer and closer and characteristics of more than one condition may be present in one patient. Muscular trauma and strain may simulate polyarthritis. Fatigue, especially in younger children unable to recognize or express fatigue symptoms accurately may simulate polyarthritis. Subjective symptoms, not objective signs, of pains in the legs, especially at bedtime and relieved by massage and manipulation and called "growing pains" can be identified easily. New concepts of growth, especially the spurt of growth and metabolic adjustment during adolescence, may place a different interpretation on "growing pains." This is the symptom, and the finding of a so-called cardiac murmur, which leads to most mistaken diagnoses of rheumatic fever.

Occasionally other diseases may present symptoms simulating rheumatic fever. Of this group, three are important: poliomyelitis, leukemia and osteomyelitis.

Carditis

Carditis due to rheumatic fever can be suspected, even if not proven, in each case. It is more apt to occur in younger people and in sequential attacks. The cardiac lesion may be acute and reversible, probably is so in most cases and may be chronic and may be irreversible, strangely different from lesions of rheumatic fever in other organs and parts of the body. Pancarditis is possible and more frequent in younger people. It is made up of varying components of myocarditis, endocarditis and valvulitis, and pericarditis. It is the one important effect of rheumatic fever because it is the only one which can be irreversible. If a patient has an attack of rheumatic fever, the cardiac damage is the main problem which lies ahead.

The cardiac lesion can be recognized, if sufficient in quantity, by enlargement of the heart, alteration of the quality of the two cardiac sounds, particularly the first sound at the apex, and disturbances of mechanical co-ordinated function, the ability to move blood through the chambers of the heart and the peripheral areas of the body, and intrinsic disturbances of mechanism. Determination of these signs can be worked out on physical examination by procedures known to all.[6]

Associated with these changes, certain adventitious signs have been found to indicate cardiac lesions, notably thrills and murmurs due to changes in the caliber of the circulatory channel through the heart. These changes can occur from obstruction, constriction or projection within or into the channel, or from changes without, resulting from pressure or shift in position of the channel. Presystolic apical thrills are always significant of stenosis of the mitral valve with ad-

vanced heart disease. Other thrills are found infrequently in rheumatic heart disease. Great importance is often attached to cardiac murmurs; much confusion exists as to their interpretation[2,3,4] and many mistakes in diagnosis are based on over-emphasis on murmurs of no pathologic significance. Murmurs have intensity, duration, pitch, time in the cardiac cycle and a location on the chest wall. Terminology should be based on these primary qualities. Well-defined, apical, systolic murmurs are usually present in cases of rheumatic carditis and are associated with mitral valve insufficiency. Faint, mid or late diastolic apical murmurs due to mitral valvulitis and a failing heart are usually missed. Loud presystolic murmurs are called systolic in time and alterations of the first sound at the apex due to stenosis of the mitral valve are confused with other signs. Faint mid-diastolic murmurs heard best along the left sternal border, best heard in the upright position, are often missed because they are not listened for, or because they are overshadowed by other and louder sounds and murmurs. These are the four important cardiac murmurs of rheumatic carditis. Murmurs which do not fall into these four categories and with these qualities can be discarded or must be accepted with reserve until they are proven to be significant. An understanding of acoustics and the use of an electrophonocardiogram and experience will assist in one's own ability to classify cardiac murmurs. A persistent apical systolic murmur in the absence of other signs of cardiac damage, means no more than that valvular scarring has occurred from a previous carditis and as a sign means "Kilroy has been here."

Pericarditis can be recognized by friction rubs and fluid exudate. Rubs are missed often because they are not listened for or because the sign is transient or not present when the pericardial sac is distended with fluid exudate or is obliterated. They are easy to recognize and are best and most often heard along the left sternal border; they may be confused with cardiac murmurs. Friction rubs are more often heard than felt.

Carditis must be differentiated from congenital anomalies of the cardiovascular system. The character of the murmur is the confusing sign, though when there is chamber enlargement, the differential diagnosis can be difficult. Improved techniques of angiocardiography have made important contributions to an understanding of the physical signs. In most cases a diagnosis of the general nature of the cardiac lesion can be made.

There are no diseases which resemble rheumatic carditis.

Chorea

Chorea minor (encephalitis rheumatica) is recognized by disturbed motor and emotional patterns. The basic reflex pattern is altered and characteristic movements of face, extremities, speech and body position develop when the part goes into voluntary or semivoluntary action. Signs disappear during sleep, and are intensified by excitement or intention. There is involuntary muscular contracture but no convulsive disorder. Disturbances of emotional patterns likewise are usually present. These disturbances vary and lack a fixed pattern. The motor disturbance may be predominantly one-sided and is usually on the lesser dominant side. There are no sensory changes. The disease is always reversible with no residual change. Chorea may be caused by psychogenic disturbances such as, motor and emotional reactions in crossed cerebral dominance (strephosymbolia), hysteria and emotional stress.

Chorea may be confused with poliomyelitis and organic lesions of the CNS such as cerebral palsy and athetosis. It is confused most frequently with facial tics and habit spasms. The distinction should be easy to make since tics and habit spasms have a fixed pattern of expression at any one period, though the pattern of the spasm may change.

This is the picture of the rheumatic constellation in its clearest expression, the planets which have the greatest luminosity and visibility. They can be seen by the naked eye when one looks and when the constellation is above the horizon. Lesser planets, the minor expressions, are erythema, subcutaneous nodules, fever and lesions in other viscera.

Erythema marginatum is an exudative lesion and is similar to the arthritis and some of the anatomic lesions in the heart and body tissues. Its presence indicates activity of rheumatic fever and can be used as visual education to explain activity to patients when other signs are absent.

Rheumatic subcutaneous nodules, proliferative lesions found in tendon sheaths, aponeuroses and certain bony prominences, all poorly vascularized areas, are similar to the characteristic Aschoff nodule in cardiac muscle and are diagnostic of

rheumatic fever. They occur more frequently during periods of recovery and represent repair of tissue damage.

Fever is the expression of the disease from which rheumatic fever derives the other part of its name. It is present in some degree and at one time or another in every case. It is high in the acute attack, is higher in adults, and is difficult to estimate at other times. The fever curve has no characteristic diagnostic pattern and should never be the single criteria, taken alone, of rheumatic activity.

A discussion of associated lesions in lung, abdomen, kidney and maybe in other viscera is beyond the capacity of this paper. Both substantiating and differential diagnostic signs of them can be worked out. The situation is rarely difficult for such lesions occur only rarely without one or more of the three major expressions of rheumatic fever.

A group of symptoms and signs are often mentioned as being related to rheumatic fever such as abdominal pain, epistaxis, fainting, cardiac discomfort and heart consciousness. None of these are significant. These are asteroids, inside but not a part of the constellation. Abdominal pain may be due to rheumatic peritonitis or to rheumatic disease in the abdominal arteries, but is usually a behavior disturbance or a visceral reaction to acute tonsillitis or nasopharyngitis. Epistaxis in severe form occurs in rheumatic subjects with advanced activity, but is more often due to trauma or to increased vascularity and congestion of the nasal mucous membranes. Syncope and discomfort, usually palpitation, have no significance in the patient who complains of them. When the signs are present the patient has advanced degrees of carditis. These symptoms and signs are far removed from the constellation.

When the orbit of the constellation passes near or below the horizon and the patient passes into a period of remission, the situation is not simple and easy. Even with the telescope the planets are gone. One must wait until they reappear, hoping they never will, and taking care that everything is done to delay or prevent their reappearance. Maybe presumptive evidence can be seen in the horizon in the trail of the major planets when the focus is sharpened. Under such study and test periods evidence can be accumulated. If the sum total of this evidence is great enough it becomes more confirming than presumptive. The following procedures may be carried out to evaluate presumptive evidence.

1. Careful basal body temperature at selected times of the day when the temperature is apt to be the highest and lowest. The normal high should be 37.4°C, the range 1.0°C in the test period of at least five days.

2. Careful basal heart rate count to coincide with temperature readings, if possible a sleeping pulse rate to get the lowest rate. The normal high in young children should be 100/min., or less in older ones. Return of accelerated heart rate after effort to the previous resting rate within a reasonable time together with an estimate of the amount of work required to produce an unusual rise or a delayed return. Every subject has his own characteristic resting pulse rate and response to effort or emotion.

3. An estimate of nutritional status by weight curve and charts and by physical examination. Rheumatic fever is associated with a nutritional deficit obvious or obscure. A deficit is the one main characteristic of "below par," either below or above weight, children and does not often escape the careful observer. Metabolic studies may occasionally be necessary to show all the changes in deficits and negative balances.

4. Rheumatic fevers injures the blood-forming structures and anemia is a constant feature during sustained periods of activity. It is more than can be explained by nutritional deficit of iron and protein. It may be the cause of dyspnea rather than cardiac failure or salicylate intoxication. Sickle-cell anemia can simulate rheumatic fever closely and every Negro patient suspect must have moist droplet blood examination.

5. The hemogram usually is not disturbed though young adults may show a shift to the left and the total neutrophil count may be high during acute attacks. No statement can be made at present about the reliability of total eosinophilia as an index of rheumatic activity. The total count may rise and fall and may be modified by steriod compounds and the mechanism of eosinophil production may be more sensitive in the rheumatic subject. Increase of the ESR is an index of activity of some form of infection. A single determination showing an increase is presumptive evidence in a rheumatic patient suspect. Serial determination showing a sustained increase is confirming but active infection elsewhere and otherwise may be the cause.

6. Roentgencardiograms, electrocardiograms and electrophonocardiograms made under standard conditions reveal information which is invaluable and which cannot be obtained elsewhere or otherwise. Again, evidence on a single examination may be only presumptive; on serial examination it is confirming. Alterations in cardiac size and shape, change in point of origin, conduction time and distributions of the cardiac impulse, alterations of the QRS complex, and disturbances of mechanism, particularly the finding of ectopic foci of control or origin of cardiac impulse can be determined and can be recorded graphically. These procedures must be made in conjunction with careful, searching, thoughtful physical examination. Changes in these findings are for better or for worse, a *status quo* is hopeful. Back of them all is the intelligence and experience of the examiner, who puts each in its proper place, or in the discard.

When careful search reveals no positive sign or group of signs the testing should be discontinued. When symptoms reappear, if they do, the testing can be carried out again and again if necessary.

Experience shows that certain secondary factors are associated with a higher incidence of rheumatic activity and it is in these areas that surveys are productive of accurate testing and a greater yield of cases. Accumulation of symptoms and signs from the anamnesis is notoriously unreliable. When certified by medical examination and recorded, they become permanent in the record. The conditions and events under which rheumatic fever occurs more frequently or more severely are: in the spring season; in physically and emotionally "below par" children[1]; in population areas of low economic and social security; in siblings of a known patient; in families with low health standards and habits. First attacks occur more frequently in age five to nine year semidecade. Recurrent attacks are associated with a rise in incidence of heart disease. Chronic heart disease occurs most frequently in age ten to fourteen year semidecade. Rheumatic fever at six, rheumatic heart disease at sixteen years of age should point the emphasis in the study. Geographically, the frequency distribution of rheumatic fever is related directly to streptococcal infection. It occurs as Phase III following streptococcal infections and re-examination of patients a fortnight after acute hemolytic streptococcal infection will produce a high yield of cases.

The nature of rheumatic fever has been confused further since the observation that steroid compounds, notably cortisone and ACTH (Armour), affects profoundly the course of rheumatic fever. This suggests that factors other than streptococcal infection may operate to render an individual subject to rheumatic fever or to initiate and activate rheumatic fever attacks. The information immediately available does not indicate whether the effect is on the host or on the disease mechanism. The use of these substances alters profoundly the subject and there is suggestive evidence that the rheumatic subject has a mechanism which is more sensitive than the normal subject. If this hypothesis becomes established as fact, many more diagnostic criteria will be required to identify the rheumatic subject and to evaluate the degree of activity of rheumatic fever. No final statement of this possibility can be made now.

Emphasis has been placed more and more, probably too much, on information derived from laboratory tests and procedures. These are all helpful and suggestive. They may be presumptive or confirming. Eventually, one, a polar star, which is specific, will be worked out. For example, the finding of tubercle bacilli in the sputum, a high sugar content of blood and urine or blast cells in the marrow or circulating blood are each confirming and positive diagnoses of the conditions they represent. But the final word should be said on experience and judgment which should be based on accumulation of all information, fully evaluated and applied to the individual situation. Unless the criteria are positive it is imperative that the situation be held in abeyance and under observation and that the individual receive no stigma of a false diagnosis. No diagnosis should be presumptive. If the signs are positive, it should be "yes"; otherwise, no diagnosis.

Summary

The problem of diagnosis of rheumatic fever and the management of patients will remain a large one. It should rest in the hands of the family physician, the general practitioner and the pediatrician, who is mostly a general practitioner. The over-all direction of programs of care and follow-up will require the specialized services and advice of the specialist who may be needed in a few doubtful cases for diagnosis.

If the problem must rest in the hands of the family physician he must be willing to take time

(Continued on Page 1433)

Diagnosis of the Acute Rheumatic State

By Saul Rosenzweig, M.D.
Detroit, Michigan

ALTHOUGH rheumatic fever is protean in its manifestations and ubiquitous in its visceral distribution, it has no clear-cut common denominator for its diagnosis. It may be as simple at times to diagnose as the case of the full-blown herpes zoster, or as difficult to diagnose as the pea-sized primary carcinoma of the prostate that the pathologist finally shows us. There is no pathognomonic sign such as the acute flaccid paralysis of poliomyelitis to point the diagnostic way; there is no definite tell-tale historical note of colicky pain to suggest calculus; there is no diagnostic laboratory test like the Wassermann, or the classic x-ray of pulmonary tuberculosis, or the exact electrocardiographic pattern of myocardial infarction. So to make the diagnosis of the acute rheumatic state all the data of history, examination, laboratory approaches, even heredity, must be evaluated. This suggests, and it is true, that a full knowledge of the variants of this disease must be known to arrive at a diagnosis; indeed one may speculate whether rheumatic fever is a disease at all, for in recent years it has been shown by Arnold Rich, Kerr and others that a more or less common pathological denominator designates all the collagen diseases, of which rheumatic fever is perhaps the most common clinical syndrome. This explains readily the overlapping, for instance, of rheumatic fever, Still's disease and lupus erythematosus disseminatus.

But we clinicians must leave this speculation to the researchers in pure science when we have a patient whom we suspect suffers from acute rheumatic fever. Diagnosis is of the utmost importance in the *active* stage as the probable benefits of therapy depend on it, for it is well accepted that it is during the *active* stage of this disease that the myocardium and endocardium receive their severest injury and only months or years later be recognized as the full blown valvular heart disease. It is not within the province of this paper to meditate on why, although any or all organs may be initially involved in the rheumatic infection, only the cardiac apparatus receives a more or less permanent damage, but it is on its multiple organ manifestations that aid can be derived as to diagnosis. The acute phase of rheumatic fever has been described as (1) *monocyclic* or, (2) *polycyclic*, with (3) an uncommon *continuous* form; it is often thought that adults commonly have an acute monocyclic form while children have the polycyclic form; this is a generalization that I am not prepared to accept, for the more one follows these cases the move evidence there is that almost all cases have a chronic active or latent stage. This latter assumption perhaps accounts for so much failure in handling this disease even with thorough-going care; this also accounts for the fact that more exacerbations which climb over the clinical horizon occur primarily in the first few years after the initial active episode.

In arriving at a diagnostic conclusion in acute rheumatic fever it is well known that certain manifestations are more significant than others. Thus, it is common to divide the clinical evidences into (1) *major* or perhaps *presumptive* evidence, and (2) *minor* or *possible* evidence. The following might be such a grouping:

Major Manifestations.—(1) *Migratory* arthropathy, (2) carditis, (3) chorea, (4) subcutaneous fibroid nodules, (5) characteristic electrocardiographic findings, (6) minor evidence in an established rheumatic valvular heart, (7) therapeutic test.

Minor Manifestations.—(1) Fever—as sole evidence of disease, (2) skin rashes, other than nodules, (3) tachycardia, (4) precordial pains, abdominal pain, (5) epistaxis, nasal—less so renal (6) pneumonitis, pleuritis (debatable), (7) growing pains (debatable), (8) erythrocyte sedimentation rate, (9) antistreptolysin—0 titer.

This list seems, and is, quite a formidable one, yet it is well known that in spite of it many cases may be so mild or masquerade as other conditions that both parent and physician may with painstaking intent still miss the diagnosis.

Arthritis.—The typical joint involvement has been described as acute, migratory, hot, red, possibly swollen, and painful. This type is exceedingly rare nowadays, and a much milder form of arthropathy is usually encountered. Sometimes one merely finds an aching, slightly stiff joint;

Delivered at Eleventh Annual Clinic Day, Mount Carmel Mercy Hospital, Detroit, January 25, 1950.

at times a child can't run as hard as usual and complains of limp or indefinite pain and examination reveals none of the mentioned classical criteria of arthritis. Growing pains probably belong in this mild form, usually occurring behind the knees. Nonrheumatic growing pains usually occur at night. Most of the terror in mothers of rheumatic fever is due to the too widespread feeling that painful limbs and heart disease are practically synonymous. While it is wise to make a careful review of such mild suspect cases it is equally wise to do our utmost to prevent this mass cardiac neurosis that we, press and radio may cause. It is also well to remember that rheumatic fever without any recognizable joint manifestations is quite common especially in children, in perhaps *fifteen* or more per cent. It is of great help in evaluating any joint manifestation to recall that the rheumatic joint involvement usually follows an upper respiratory infection or other infections with certain types of streptococci —Lancefield A. The more common joints involved are the larger ones of the extremities but smaller joints are not immune; involution in some days or weeks occurs without residual—unlike as mentioned—the heart. This cycle may recur and become the socalled continuous form.

Fluid aspirated from the joints is sterile but is turbid with many leukocytes. Usually the severer forms of arthritis are seen in adolescents or adults rather than children where the carditis is more severe; but probably no rule in medicine is more frequently broken than this one.

Carditis.—This is a very useful term, but it actually means a *pancarditis.* The disease may devastate any or all of the three layers: pericardium, myocardium, and endocardium, but practically always disproportionately. Probably all acute rheumatic fever is associated with active carditis; this is especially true of children, the older the patient the less evidence of severe involvement is found; however, since adults with mild cases do not die, pathologic proof of involvement is not proven. The subjective evidence of carditis is usually meager; only an occasional case will complain of dyspnea, palpitation; possibly slightly more frequently one notes precordial pain; a rare acute carditis will fulminate into congestive failure and the symptoms of failure will ensue. Fever frequently is found as an evidence of active carditis.

Myocarditis.—Although involvement of the endocardium is so frequently recognized by the tell-tale murmurs and in later stages of the rheumatic state bears the brunt of the disease, however early in the disease it is the myocardium that is the more importantly involved. This is seen in the loss of reserve noted in the acute attack while reserve greatly improves with subsidence of the bout, even with persistence of a valvular defect. It is therefore accepted widely that frank congestive failure in young rheumatics *cannot* occur without *active* or acute myocarditis. It is because of this fact that the child with rheumatic heart disease should fear the acute respiratory infection heralding exacerbation more than e.g., playing football. Probably the tachycardia which is out of proportion to the fever encountered is due to myocardial involvement; the more serious forms of arrhythmia such as auricular fibrillation are also an index to gravity of myocardial involvement. Impaired heart tones; newly appearing third heart tone, gallop rhythm are also evidence of myocardial involvement. Changes in size of the heart by x-ray are also most likely a mirror of myocardial involvement. Ease of fatigue in the absence of other causes can also be blamed on the impaired myocardium in a rheumatic suspect.

Pericarditis.—This involvement to a recognizable clinical degree is not common in adults but frequent in the severer involvement of the heart in children. However there is some evidence (by Samuel Levine) that if the disease burns itself out with pericarditis as the major manifestation there may be some sparing or less grave involvement of valves. The evidence of pericarditis is the rapid, and at times characteristic x-ray enlargement of the heart shadow—the so-called water-bottle shaped heart; the electrocardiograph also is of considerable though not uniform aid; briefly these signs are decrease in voltage of the ventricular segments, and non-reciprocal elevation of the RS complex; frequently the T wave may become low, dome shaped or inverted. The diagnosis is best established by the hearing of the friction rub; this is the biphasic loud, superficial "double-shuffle" sound. The sound may be so loud as to obscure totally the heart tones, while in the large effusions the peculiarly distant tones make the suspicion of the pericarditis likely. In rheumatic pericarditis the friction usu-

ally is heard even with large effusion, in which case it is best heard at the base where the pericardium reduplicates itself over the great vessels. Ewart's sign (dullness and tubular breathing at the angle of the left scapula) is encountered in large pericardial effusions.

Valvulitis and *Endocarditis.*—The valves are oftener disproportionately involved than the mural endocardium and the left side of the heart more so than the right and the mitral more than the aortic valve. The murmurs that arise from the acute involvement of these valves usually persist as valvular heart disease but occasionally they may disappear, especially in acute aortic insufficiency. A transient diastolic murmur may at times also be found in acute cases at the mitral area due to dilation of the auricle and ventricle with "relative stenosis" of the less dilatable mitral annulus. True stenosis, the proliferative lesion, probably develops only after many months or years, with probably a minimum of three-four years. Although these acute murmurs are mentioned here as evidence of valvulitis it is of course clear that myocardial involvement also plays a pertinent part in their production. The commonest murmur of acute carditis is soft, systolic in time, and apical in location. On the other hand this murmur is heard in almost any acute illness or commonly even without any illness in children. It is upon this rock that the diagnosis of acute rheumatic fever very often founders; so it can be categorically stated that this murmur should never be the sole criteria of rheumatic fever without other better evidences of the disease. An associated thrill would be of aid in evaluating a systolic murmur, but this practically never is found in acute rheumatism. The functional systolic murmur is often basal, related to phases of respiration, exercise, position. A good rule if not too rigidly adhered to might be, that the diastolic murmur always means severe organic involvement, while the soft systolic murmur always is functional if without corroborative evidence.

Chorea.—When this is the sole evidence of the acute rheumatic state there is some uncertainty whether it is a true rheumatic manifestation. The age incidence i.e., almost always before pubescence; the absence of fever, or an acceptable pathology; the large number of girls, 5:1; the psychiatric relationship, normal EKG, normal sedimentation rate, and above all the relatively rare development of late valvular disease—only two per cent—lend some weight to this argument. In spite of such intriguing differences it is nevertheless true that chorea is more frequently associated with other major manifestations of rehumatic fever.

The onset of chorea may be insidious (the rule) or acute, especially after emotional stress. The typical choreic movement is purposeless, unco-ordinated, it is brief, nonsustained, irregular, nonsymmetric. Smaller muscle groups are most involved such as toes, fingers, lips, etc.; however, if the condition progresses larger muscle groups may be involved, so there may be ataxia, stumbling, et cetera. Intention or excitement increases the purposeless activity, but sleep stops the movements. Weakness often develops in such muscle groups and pseudo-plegias may be noted, the socalled "chorea sine chorea." Choreic patients may have disturbances in mental state, with irritability of various degree up to acute mania.

There are several signs which aid in diagnosing the choreic movements:

1. The pronator sign, in which the palms are pronated on extending arms over the head.
2. The choreic handclasp in which there is rapid maximal contraction with equally rapid relaxation with alteration of tone during this action.
3. The "choreic hand" of ten shows flexion of the wrist with extension of the fingers.

In the fully developed choreic the movements need no especially diagnostic skill, however tics in impressionable girls may be differentiated by such tests; moreover in the tic or habit spasm the one or two movements are constantly repetitive. However, some choreics develop tics themselves—a baffling combination. Athetosis can readily be differentiated by its worm or snake-like, slow, twisting character of the movement.

Subcutaneous Nodules.—Although the presence of nodules is a major evidence of the disease, there is a marked variability in the expected incidence, there being an involvement in from 2 to 75 per cent of cases from year to year and from location to location. However, when found they seem to be a quantitative evidence of grave involvement, but not necessarily a sign of grave ultimate prognosis. They are much oftener seen in children than adults. Nodules are subcutaneous, pea to

bean sized, painless, freely moveable, often in crops, usually last weeks to months, involute without residue. They are found about the malleoli, the patella, elbows, on the extensor endons of the hands, in the scalp, or along the spinal column. Pathologically nodules indicate the proliferative rather than the exudative aspect of the disease and thus are of themselves indicative of the subacute but active stage of the disease. Nodules also are found in rheumatoid arthritis with equal frequency to rheumatic fever, so (unless one considers these two conditions variants of the same disease process) we must look for other criteria of the one or the other, as in both conditions from clinical and histological aspects they are strikingly similar. Although nodules are seen in many other conditions, such as sarcoid, erythema nodosum, erythema induratum, Heberdens node of osteoarthritis, Von Recklinghausens disease, lupus vulgaris and erythematosus, and lues, in none of these is the nodule at all possible to be confused with the rheumatic nodule, once having been seen and felt.

The Electrocardiograph.—This is a most useful adjunct to the study of the rheumatic state. The graph can give much information not only in diagnosis, but also in progress of the disease, its pathology and even the ultimate prognosis. But it is not all things to all men, nor should it be expected to blanket the field. We have found as well as many others that all the changes formerly considered almost pathognomonic for rheumatic fever are encountered in many acute diseases, infective and degenerative both in childhood and in adults. In children, for example, anemias, poliomyelitis, bronchiolitis, pancreatitic fibrosis, all of the collagen diseases, etc., can show EKG patterns similar to those of rheumatic fever, at times with the same frequency. The experience with diseases in adults is similar; typhoid fever, acute nephritis, pneumonia, are examples. In truth probably all pathologic states if severe enough to impair the myocardial oxygen consumption will give abnormal patterns at times similar to those of rheumatic fever. I should say that probably the sins of commission are greater than those of omission, i.e., that we have become more dependent on this test than warranted; for example, a negative or normal graph can never be the sine qua non to exclude a diagnosis of rheumatic fever. A single normal tracing is much worse than having no tracing at all if one is prone to lean on this reed. So it is our practice to take frequent graphs, usually every week, or more frequently, as serial graphs are infinitely more helpful than the single tracing for the determination of acute carditis.

Our order of significance of abnormalities in the electrocardiogram is:

1. Serial changes in conformation of the various complexes: P, QRS, R, T.
2. Prolongation of the atrioventricular conduction time (PR time).
3. Prolongation of the ventricular conduction time (QT time).
4. Gross abnormalities of rhythm.
5. Abnormalities due to pericarditis.
6. Minor changes: Tachycardia, absence of normal sinus arrhythmia in children, et cetera.

1. *Serial Complex Changes.*—If frequent graphs are taken the large majority, probably over eighty-five per cent of cases, of rheumatic fever will show changes that in a single tracing might be termed normal, while serial changes are definite evidence of an impaired myocardial state or carditis. It is a well known fact that for a given individual from day to day his tracing will show little or no variation with a constant rate, same technique and same external conditions of heat, respiratory state, etc. In this regard in the normal subject serial graphs may be as fixed a part of the personal makeup as his finger prints. In acute rheumatism the auricular complex, the P wave, may show broadening, or flattening; the bifid P wave is rather unusual in the acute state, more often being seen in chronic valvular disease with auricular hypertrophy. Inversion of the P wave usually means an ectopic auricular focus of primary excitation. Serial alterations in form and direction of the QRS are frequently found if searched for. RST segment displacement up or down is occasionally seen even in the absence of pericarditis or excessive tachycardia. Abnormalities in the T wave are probably the most frequent serial change in rheumatic fever, just as it is most sensitive to change in other conditions that alter the EKG pattern. The T, especially in lead one and two, may be altered in shape, even beaked, but alterations in voltage are more frequent, so the height of the T_{1-2} should be watched carefully; flattening or inversion occur

often in severe rheumatics; and return to a normal, fixed shape and height of T can be used as a gauge of improvement. It may be said that possibly the chest leads in children, since their normal variation is so marked, add little to the data derived from the conventional leads.

2. *Prolonged PR Time.*—This is classically the most significant abnormality found in acute rheumatic fever. However in the single tracing it is found in only fifteen per cent or less of children and less frequently in adults. The normal PR time varies greatly with age, the younger the shorter the time. In the lower school age child, .16^{sec} probably is maximal. The maximum for the high school child is about .18^{sec} and for the adult, .20^{sec}. With these as standards serial prolongations or even progressive lengthening of the interval within the normal limit is significant. Moreover a slight progressive increase in PR in the presence of a more rapid rate is of more note than a fixed high normal time. PR prolongation is not usually permanent and thus may be used as a guide to improving carditis; as a rule, though, the improvement precedes other evidence of active carditic involution; occasionally however the delay may last for months, and rarely be permanent. Higher degrees of heart block are not frequent although severe cases may show 4:1, 5:1 block. I have seen Wenchebach's type of heart block only two or three times in the course of rheumatic fever. I have never seen complete dissociation in uncomplicated rheumatic fever; when found it is usually due to the use of digitalis in the disease or in old rheumatic heart disease. PR delay of course is found in many other conditions, such as acute nephritis, degenerations of advancing age, subacute bacterial endocarditis, diphtheria, etc. Whether PR delay represents a quantitative estimation of the severity of the carditis is debatable; certainly it is a measure of diffuse myocardial involvement; however all are agreed that in most cases even with high grade block is it not a bad prognostic index for the late or distant effect on the heart, except in the uncommon permanent case of A-V delay.

3. *Prolonged QT Interval.*—Prolongation of ventricular systolic time according to L. Taran either absolute or corrected (QTc) occurs in ninety per cent of cases of rheumatic fever in the stage of acute invasion with carditis and according to him is a "function of the severity of involvement and not of the rate and thus can be used as an index of the activity of the carditis." In our experience we have not noted so high a percentage deviation from the normal.

4. *Gross Abnormalities of Rhythm.*—These are not a frequent finding. There is some quantitation between the graver forms of arrhythmia and severity of carditis. Auricular fibrillation is occasionally seen in the first bout of rheumatic fever but oftener it is seen in exacerbations of the disease in an already injured heart. When it occurs in the primary episode fibrillation is usually paroxysmal and transient, in the later old cases often persistent. Nodal rhythm, auricular flutter and paroxysmal tachycardia are less frequently encountered in the acute rheumatic state, the latter two when found are usually in adults with already damaged hearts, while nodal rhythm is not too rare in children without carditis.

5. *Pericarditic Changes.*—These have already been mentioned in discussion of pericarditis.

6. *Minor Electrocardiographic Deviations.*—These usually need no electrocardiograph for their discovery. The EKG merely, for instance, gives one a permanent record of the degree of tachycardia. The cessation of the normal sinus arrhythmia in children can also be readily ascertained clinically, but in the presence of tachycardia it may be difficult. The graphic demonstration of the return of sinus arrhythmia is of some value in determination of an improving myocardium.

Extrasystoles are not rare in rheumatic fever, but are neither of diagnostic nor prognostic import. The types seen are auricular the commonest, less so ventricular; occasionally an interpolated one is seen. Sinoauricular arrest, with or without ventricular escape has been noted by us occasionally. Ectopic pacemaker is also seen rarely but I believe is of no significance in evaluation of this disease. Intraventricular delay, transient, is also a rare finding, but probably is of more than minor significance.

Minor Evidence in a Known Valvular Heart.—This seems to be a fair conclusion of diagnostic significance. The emphasis in a known cardiac is obviously in favor of evaluating any evidence as

of more than passing moment as rheumatic fever is so prone to be recurrent, repetitive, or latently continuously active. It may be put otherwise, that one with a normal background should not be diagnosed as active rheumatic fever without major evidence, while the known rheumatic valvular heart case should be considered as reactivated on minor criteria.

Therapeutic Test.—It is often impossible to arrive at a diagnosis in a suspected case as all the previously mentioned major criteria may be absent or equivocal. One or more of the minor criteria may be present but so many other illnesses have such evidence that diagnosis is extremely hazardous. It is this case especially in the acute exudative phase early in the disease that the exhibition of the specific salicylates in adequate dosage may give a dramatic involution of signs, symptoms and laboratory tests, that the inference of the acute rheumatic state is warranted. A quantitative corollary of the therapeutic test perhaps can be obtained by an estimation of the mucopolysaccharide of the cement substance of connective tissue hyaluronic acid. Salicylates it is known inhibit the spreading reaction of hyaluronidase, the enzyme acting on hyaluronic acid. This action of salicylates on this system of enzymes is intriguing but not fully proven. It certainly can't be stated that the anti-rheumatic effect of salicylates is *solely* due to the inhibition of hyaluronidase, as other enzyme systems are likely to be involved.

Minor Manifestations of Acute Rheumatic Fever

The less dependable criteria of the acute rheumatic state are almost legion. I have listed some of the more likely. On very shaky ground are such other conditions as torticollis, iritis, urticaria, even schizophrenia. Certainly when no other evidence is present these are not sufficient to diagnose rheumatic fever. Anemia of a secondary type is not per se an evidence of the disease but a sequela and probably a guide to the severity of the infection. Upper respiratory infection, too, is not rheumatic but more than likely the trigger that sets off the gunshot—the acute rheumatic bout.

Fever.—This sign in an otherwise "healthy" child or young adult is probably the most difficult to assess, for it is true that a considerable number of these will eventually show other evidences of the disease. High grade fever is never subjectively and objectively otherwise negative; with thorough search these hyperpyrexias of 104 and 105 will quickly yield to a correct diagnostic inference. It is the low grade fever of 100-101 or 102 which creates the great diagnostic problem. The temperature should in these cases, be taken per oram and per rectum; it should be borne in mind too that the usual diurnal swing is not a rigid set of normals. If the temperature by both orifices is the same, say 100, the rectal temperature is more likely to be correct and normal. Thomas Cooley used to say that this case "can best be diagnosed and cured by breaking or losing the thermometer." So it is fair to state that fever alone is not a diagnostic sign of the disease, however as a sign of continued activity it is probably the commonest.

Skin Rashes.—There are numerous skin manifestations in the acute rheumatic state, the previously mentioned fibroid nodule being by far the most significant. Commoner however is erythema multiforme and erythema marginatum, Abt's Dermatitis. This is usually pale, or faun colored, widespread on the trunk, confluent, often transient, and often recurrent, occurs both in acute and chronic rheumatism. Although it is reported that erythema marginatum may be the sole manifestation of the disease I consider it extremely hazardous to diagnose acute rheumatic fever on this sign alone; however in this case time is on the side of the examiner and other evidence will appear if the search is sedulous.

Purpura.—The so-called purpura rheumatica is well known; it is a symptomatic type of purpura and usually when found is in the graver type of acute rheumatism. Urticaria has been mentioned. Erythema nodosum as an entity is readily diagnosed but its etiology is likely to be tuberculous or due to other infections, as well as occasionally a manifestation of rheumatic fever.

Tachycardia.—As the sole evidence of acute rheumatic fever this certainly is a weak reed. Even what is a normal pulse rate is a great variable. The sleeping pulse is most valuable, as most children and even adults have a moderate or marked quickening of the pulse on the approach of the physician who is epitomized as "that man with the needle is here again." However if the pulse is rapid and irregular it *is* of significance and if the arrhythmia is not well told by examination the electrocardiograph will be of diagnostic aid. Even

in the absence of other criteria the young fibrillator is likely to be rheumatic, though usually of the chronic type.

Pain—Precordial, Abdominal.—Precordial pain in children is more significant than in young adults where "effort syndrome" is the more common etiology. This anginoid syndrome of rheumatic fever is relatively rare but when present indicates a severe episode of the disease; various authors have shown a coronary arteritis in rheumatic fever which readily explains the pain; in wide open aortic insufficiency there is often angina too but here it is not an arteritis but impairment mechanically of coronary flow. The epicarditis with pericarditis frequently causes angina but here the friction sound is of great aid. Abdominal pain may cause confusion in diagnosis; a mild serous peritonitis is found rarely in rheumatic fever; if diaphragmatic it may be told by its distribution, perhaps by a friction sound; however if localized to the lower abdomen appendicitis has been diagnosed; if this is borne in mind an occasional laparotomy may be avoided.

Pneumonitis, Pleuritis.—Since rheumatic fever is entirely a vascular disease, true pneumonitis is unlikely. But arteritis with hemorrhage and the consequent pseudoconsolidation does occur and may be recognized clinically as a pneumonitis. When found however other evidences of acute rheumatism are often found. I agree that this stand is sitting on top of the fence but that is where I prefer to stay—precarious as it is. Moreover it should not be forgotten that true pneumonia as a complication or sequela of grave illness can be found following rheumatic fever as well as any other acute illness. Pleuritis does occur however and perhaps is an extension from pericarditis, or like pericarditis or peritonitis a separate evidence of serous sac involvement.

Growing Pains.—This sign of acute rheumatic fever has been mentioned above under the arthritis of rheumatic fever.

Epistaxis.—Although not an important criteria of acute rheumatic fever it is true that non traumatic nasal epistaxis is commonly associated with the acute state. It has also been noted to herald a recrudescence as well as being an evidence of continued activity of the disease; microscopic renal epistaxis bears a similar relation to the disease. Pathologically these signs probably represent another evidence of the vascular nature of the disease.

The Antistreptolysin-O Titer.—The reaction in acute rheumatic fever to the hemolytic streptococcus agglutination test is uniformly negative but the antistreptolysin-O titer is high in ninety per cent of cases. In the atypical or smouldering case the antistreptolysin-O titer can thus provide additional diagnostic aid.

The sedimentation rate may better be mentioned later as an evidence of continued activity rather than diagnosis.

The Inactive Rheumatic State

Having arrived at a diagnosis and having accomplished a more or less successful therapeutic result of the acute phase the question that arises next is, what in this insidious disease are the criteria to warrant instituting convalescent care? If we accept the pathologist's data that rheumatic fever is never cured we can obviously be at once stymied for many pathologists have shown in painstaking search of chronic as well as acute rheumatic fever that post-mortem material almost uniformly has underlying *active* infection. Paul White puts this situation thus: "how can we determine with certainty the presence or absence of activity of the rheumatic infection during life," with his answer being in the negative.

This is the same dilemma as in tuberculosis where no cure can be vouched for, but the students of this disease like us have made a modus vivendi between the pathologist and the clinician. So, when we list the criteria of activity or inactivity of the rheumatic state one really means the criteria of *sufficient inactivity* of the disease process to warrant with the least risk the institution of increasing increments of physicial stress by the patient.

In the previous discussion of the diagnostic criteria much can be used also as evidence of continued activity. To avoid redundancy and to make a formula of attack of the problem as obvious as possible we can omit the clear evidence of acute activity, such as febrile arthritis, pericarditis, chorea, and the like signs, and consider only the case for latent activity.

The following, then, is my list of criteria which must be *totally* satisfied to institute convalescent care.

All these must be absent:

Evidence of Latent Activity.—(1) Patient has symptoms, (2) subcutaneous nodules, rarely erythemas, (3) tachycardia, (4) changing murmur, (5) changing size of heart, especially on x-ray, (6) elevated sedimentation rate, (7) abnormal blood count, (8) abnormal EKG, (9) minor signs: weight, exercise tolerance, urinary changes, vital capacity.

This formula for proof of activity need not be elaborated upon *in extenso*. Moreover even with a comprehensive rule of thumb there are frequently found cases where clinical acumen and long continued observation are even more important. The first criteria: the symptomatic child—is as elastic as the examiner's interpretation; in this group may be mentioned "pains and aches" not classically of the migratory arthritis type; precordial distress; another such symptom is easy fatigability, both physical and probably mental. Frequent nontraumatic nasal epistaxis occasionally is a symptom of latent activity of the disease.

The presence of subcutaneous nodules is one of the most important signs of continued rheumatic activity in the proliferative rather than the exudative stage of the disease. Unfortunately, as previously mentioned they are not uniformly, nor even to a predictable degree, present. *No* patient with nodules should have active convalescent care instituted. Erythema is a much less dependable evidence of latent activity as often erythema marginatum occurs in the rather acute stage of the disease, although occasionally erythema is found associated with nodules.

Since the heart bears the brunt of the damage inflicted by the rheumatic infection the cardiac apparatus should be most carefully and directly watched for evidence of continued active carditis of clinical or subclinical degree. Tachycardia, changing murmurs and changing size of the heart are three such significant signs. Afebrile tachycardia, especially in sleep, out of proportion to the clinical state, although weak evidence of latent activity, should nevertheless be suspect; rapid arrhythmias are more significant. The heart should frequently be observed as to evaluation of the usually concomitant murmurs. The functional murmur being excluded, changes in intensity of the murmur, degree of reference, the appearance early of diastolic murmurs either in mitral or aortic areas are all significant of continued active carditis. The heart often enlarges early in the invasion of the disease but gross arrhythmias or congestive failure may do the same; all are due to active infection. Thus the cardiac silhouette should be carefully observed by x-ray at intervals of one to two weeks when indicated, and we feel that both increases and decreases in cardiac diameters are evidence of activity and we should wait for a fixed x-ray cardiac area before instituting active convalescence.

The laboratory offers us considerable aid in differentiating the active from the latent rheumatic state. Some data are not uniformly present nor dependable; in this category is the blood count; in the acute exudative phase of the disease leukocytosis is usual but we feel this sign clears much earlier than other evidence of continued activity, on the other hand it may herald a recrudescence. Anemia is a poor sign of activity as it occurs in both the acute and the late latent stages of the disease; it is more an index of severity of involvement than a sign of continued activity. The erythrocyte sedimentation rate is probably the most uniformly helpful laboratory aid to estimation of continued activity of the disease. As long as the test is nonspecific and is found elevated in many conditions, degenerative, toxic and infectious, these must be excluded in each rheumatic. Occasionally a case, all other stigmata of activity being absent, shows a fixed high sedimentation rate; in this rare instance of isolated fixed high rates the test loses its value and other evidences of activity must be made the criteria of initiating active convalescent care. The sedimentation rate need not be done more frequently than every two weeks; significant changes will not occur more rapidly in rheumatic fever.

During the acute phase of the illness, urinary changes are expected and often found but insignificant findings are the rule later in the disease and certainly of insufficient import as a guide to continued activity.

The value of the electrocardiograph in diagnosis of the disease is just as significant in evaluation of activity but as mentioned before serial graphs offer much greater aid than a single tracing (85 to 95 per cent). Although some of the findings (PR delay) may be due to vagotonia and so, diminished or obviated by atropin, this does not negate the significance of the finding. We expect the electrocardiogram to return to normal or in rare

instances stay fixed in an abnormal state before inferring that convalescent care may be started. In the presence of an abnormal graph more frequent curves are warranted than sed. rate estimation, as changes occur much more rapidly, sometimes from hour to hour.

Among minor aids in evaluating activity is the weight chart. Usually, the acute rheumatic will be or become underweight. Failure to gain often corroborates other evidence of activity and conversely steady gain suggests diminution at least of the activity of the disease. In the overweight child or adult this is an undependable aid. Fatigability is also of minor aid; vital capacity may be a measure of this sign of activity, but it is of more value as evidence of beginning of loss of reserve, which of course is also evidence of activity.

Regardless of the formula we have for evaluation of activity of the disease, we can stress again that the completely asymptomatic, apparently quiescent case by all methods of objective evaluation may continue to progress insidiously, or even subclinical recurrences may occur without being found or suspected by the patient, parent or physician.

Differential Diagnosis of Acute Rheumatic Fever

Since the diagnosis of rheumatic fever itself may be very tenuous, the number of conditions from which it must be differentiated is a formidable one, and on the other hand rheumatic infection in childhood is more often overlooked than confounded with other diseases. Continued and careful observation will usually solve the problem. Several arthropathies, cardiac lesions and a larger group of more general conditions can be considered in the differential diagnosis.

Arthritic Conditions.—Tuberculous arthritis, syphilitic bone or joint disease, gonococcic arthritis, pyoarthrosis, acute osteomyelitis, scurvy.

Cardiovascular Conditions.—Subacute bacterial endocarditis, collagen diseases, hyperthyroidism, congenital cardiac defects, functional murmur, neurocirculatory asthenia.

Other Conditions.—Typhoid fever, poliomyelitis, meningococcic meningitis, brucellosis, sickle cell anemia, leukemia, bacillary dysentery, acute appendicitis, non-rheumatic choreas.

Arthritic Conditions.—Of the various types of specific infectious arthritis gonorrheal arthritis offers some difficulty, at times resembling closely both rheumatic fever and rheumatoid arthritis; the most important diagnostic features of this condition will usually clarify the problem; these are history of urethritis or cervicitis, demonstration of the organism from uro-genital tract or on culture from the suspected joint, positive complement fixation test and finally dramatic recovery on chemotherapy or penicillin with disappointing benefit from salicylates. Among all the other joint conditions mentioned, the course or recovery of a specific organism and above all a helpful x-ray will differentiate the pyoarthrosis, syphilis, tuberculosis and the scorbutic joint.

Cardio-Vascular Conditions.—Subacute Bacterial Endocarditis is confusing only in the older child; it is rare in the young school age child. Since it is implanted on an already involved rheumatic heart it is doubly confusing early in the disease. However, time, the appearance of embolic phenomena large or small, as petechia, and positive blood culture will usually make the diagnosis. All the collagen diseases especially lupus erythematosus disseminatus and rheumatoid arthritis give cardiac and arthritic manifestations since rheumatic fever may be essentially the same disease or a different allergic form thereof diagnosis can be difficult. Since the prognosis differs so markedly in the various forms it is well to try to differentiate these conditions. As lupus usually has a fairly typical skin manifestation, has a graver, usually fatal course and no nodules, a diagnosis can ultimately be made. Rheumatoid arthritis is "said to show less migratory joint manifestations," more small, permanent, abnormal joint manifestations and usually sparing the heart and has an equivocal effect from salicylates; often there are higher swinging temperatures; long observation is necessary in these cases as often borderline cases are almost impossible to differentiate from each other.

Hyperthyroidism can superficially mimic rheumatic fever, with low grade fever, tachycardia, tumultuous heart action. But radioactive iodine uptake test, basal metabolism in the older child will help in differentiating. Congenital cardiac defects at times confuse the diagnosis; but history of lesion from birth, bizarre murmurs, the diagnostic patterns in the classical defects, aided by

(Continued on Page 1455)

Arterial Hypertension

By Irvine H. Page, M.D.
Cleveland, Ohio

TREATMENT of patients with hypertensive vascular disease is based on definitive diagnosis and classification of the kind of malady from which the patient suffers. Arterial hypertension, like fever or leukocytosis, is of multiple origin. No discussion of its treatment is possible which does not presuppose an estimate of the nature, extent and rate of progress of the disease.

The term "hypertensive vascular disease" has value because it is broad and inclusive. It means a state in which arterial tension is increased over long periods of time and one which is usually associated with premature damage to blood vessels and to the tissues and organs they supply. It has no etiologic and often little physiologic connotation. It includes a most common lethal disease of adult life; namely, essential hypertension. The cause of this disease is unknown. The term also includes a variety of secondary, sometimes transitory, hypertensive states, the origin and nature of which are either known or suspected on adequate clinical and functional grounds. While this review of treatment is concerned more particularly with "essential hypertension," it is also concerned with some of the other types of hypertensive disease which simulate essential hypertension.

Essential hypertension is characterized by persistent elevation of systolic and diastolic arterial pressures. In its early stages, which begin probably in the 20's and 30's, or in adolescence, the elevations of arterial pressure are transitory, and subside promptly on rest and minor re-orientation of habit and attitude. In its later stages, the elevations of arterial pressure are more severe, more lasting, more resistant to minor modes of treatment. Finally, the levels of pressure, even at bed rest and under sedation, tend to stabilize at high levels. At any stage in the disease, but as might be expected, more commonly during the phases of persistent and severe elevation of pressure, there appear evidences of advancing arteriolar sclerosis, which are reflected in damage to the brain and, in lesser degree, to the retina, kidney and other vascular beds. With these, go signs of damage to the function of the myocardium. In a small percentage of patients, essential hypertension is manifest as the "syndrome of malignant hypertension," in which the progress of vascular damage is catastrophically accelerated with predominance of damage in the renal vascular bed The same syndrome of accelerated arteriolar damage may be precipitated by other hypertensive disease states.

The so-called "secondary" hypertensions, i.e., the hypertensive states of known or suspected origin, can be classified, according to their causes, as: (1) neurogenic, (2) endocrine, (3) vascular and (4) renal. As examples we note the hypertension in chronic porphyria as of presumptive neurogenic origin, the hypertension and nephrosclerosis of Cushing's syndrome, adrenal cortical tumor and of adrenal medullary pheochromocytoma as of endocrine origin, the hypertension of coarctation of the aorta as a type of cardiovascular hypertension and that of chronic renal disease (glomerulonephritis, pyelonephritis) as of renal origin. The therapeutic importance of such a classification and diagnosis lies in the fact that, for example, cases of pheochromocytoma and some with unilateral renal disease can be cured by surgical removal of the offending organ.

The hypertension of aortic arteriosclerosis is of particular significance in considering the treatment in hypertensive vascular disease. The increase in arterial pressure is largely, if not entirely, systolic. It is due to a failure of the aorta, which has become inelastic, to expand and adapt its capacity to the blood ejected from the heart during each beat. Consequently, there is an abrupt rise in systolic tension in the large arteries as blood is forced into them on its way to the arterioles. The extent to which systolic pressure rises depends on cardiac rate and cardiac output, and, in the last analysis, most of all on stroke volume. Consequently, anything which tends to change stroke volume or cardiac output tends to have a parallel effect on systolic tension. Thus, it is not paradoxical, but entirely logical that this form of hypertension, in which the large arteries are least elastic, is also the form in which the levels of systolic tension fluctuate most widely. Cardiac output in intact human beings is predominantly under nervous control, but varies also with metabolic rate, tissue demands and other factors. Therefore, it is a common experience that mild measures such as

From the Research Division of the Cleveland Clinic Foundation, and the Frank E. Bunts Educational Institute, Cleveland, Ohio.

rest, reassurance and sedation and control of obesity, which tend to decrease cardiac output, often have dramatic results in decreasing arterial tension in elderly people. It is this responsiveness of pressure levels in arteriosclerotic hypertension which has led so many unwary clinicians into unwarranted therapeutic claims. Similarly, the confusion of arteriosclerotic hypertension with essential hypertension (diastolic hypertension) has led many older patients into disproportionate anxiety and concern.

Arteriosclerotic hypertension, in contrast to essential hypertension, is a disease which begins in middle and old age. Usually in the 50's, transient increases of systolic tension occur, which, as time goes on, become persistent, at least during casual measurements. The diastolic pressure is little if at all increased. The underlying disease is a generalized arteriosclerosis. There are therefore to be found evidences of arteriosclerosis in the heart, brain and kidneys of most of these people. But this disease has a very slow rate of progress. Although vascular accidents can occur without warning, most of these people live to very nearly a normal expectancy of life.

The treatment of this condition is basically the treatment of old age, and of vascular complications as they appear. Many of the general and some of the more specific measures which apply in essential hypertension apply here also.

Pathogenesis

It may be well to review, very briefly, current views on the pathogenesis of experimental hypertension because it provides a background, all too limited at present, on which the physician may ultimately base more rational therapy.

There are those who believe hypertension is solely due to the occurrence of vasoconstrictor substances, those who believe it is wholly due to excessive vasomotor activity and those who, like us, believe in a combination of the two.

Evidence of a neurogenic origin comes chiefly from the bedside. The irritable, hostile, anxious patient with labile sympathetic nervous system can hardly fail to impress the attending physician with the importance of the nervous system in the pathogenesis of his disease. A scant beginning has been made in the understanding and description of the disordered psyche of those patients. Attempts have been made to reproduce neurogenic types of hypertension in animals by bilateral sino-aortic denervation. But this experimental disease has no chronic clinical counterpart that can be recognized at present.

The chief source of information on the participation of the nervous system in the genesis of hypertension has come from the operation of sympathetic neurectomy and ganglionectomy on hypertensive patients. A hesitant and uncertain beginning had been made in the use of these operations on the Continent as long as twenty years ago, but it was not until they were actively investigated as a method for the treatment of hypertension did any significant observation appear. We need hardly remind an audience of physicians of the wide variety of opinion expressed on the results of these operations, having run the gamut from "a cure" to "positively harmful." But time and observation have softened these differences. Three facts of importance may now be regarded as established: (1) arterial pressure in some patients is significantly lowered; (2) the patient is often clinically improved even when the fall in blood pressure is slight or absent; (3) no harmful effects have been observed as a result of the fall in blood pressure. While these results suggest the important participation of the nervous system in the genesis of hypertension, they do not prove it. Perhaps we are a little overcautious, but better so at this stage of knowledge in the hope that more rigid proof will be forthcoming.

No conclusive answer has been brought to the question of a circulating pressor substance as one of the causes of hypertension either in man or animals. But there again there is much to suggest the participation of the renal vasopressor system. Briefly, this system consists of an enzyme, renin, contained in the tubular cells, which acts on renin-substrate, an alpha$_2$-globulin produced by the liver, to produce a third substance, angiotonin.

Angiotonin, when injected into normal human beings, produces most of the hemodynamic changes which are characteristic of essential hypertension itself, and this constitutes important evidence that angiotonin, or something very much like it, could be the cause of essential hypertension. But so far, no one has found conclusive evidence for the existence of angiotonin in increased amounts in the blood of hypertensive patients or dogs with experimental hypertension. Either it is there and somehow active in amounts which defy our crude methods of assay, or some other substance is

responsible. We hold the view that angiotonin is the more likely.

Certainly the method currently available for the quantitative determination of renin and angiotonin are unsatisfactory except when the analysis is made on very large amounts of blood and even then the results so far have not been conclusive.

There is some evidence that a protein pressor agent is present in the blood of hypertensive patients, but it is not sufficiently cogent at present to add another participant in the genesis of hypertension.

In recent years, we have become interested in the problem of the responsiveness of the blood vessels themselves. It has become apparent that the response may vary spontaneously severalfold under what seem to be normal conditions. Thus, without any change in the concentration of pressor agents in the blood, increased responsiveness of the blood vessels could of itself elicit hypertension. We have been able to increase responsiveness by bilateral nephrectomy, destruction of the spinal cord or the administration of tetraethylammonium chloride and to decrease it by shock or the removal of the liver. The relationship of these results to hypertension is not as yet clear, but any physician with imagination will recognize the importance of changes in sensitivity of the blood vessel muscle on which pressor agents and nerve stimuli must act to control the caliber of the vessel and its resistance to blood flow.

Another aspect of pathogenesis is described by Selye. In this view, emphasis is placed on the arteriolar disease elicited by desoxycorticosterone. The suggestion is that deviant and abnormal responses to injury (psychic or somatic) cause the liberation of some such hormone from the adrenal cortex and brings the renal pressor system into abnormal activity as the result of nephrosclerosis.

Treatment

1. *General Measures.*—In a short space, it is not possible to describe in detail the general measures so important in the treatment of hypertensive patients. This has already been done in a recent manual for the patients themselves.

Perhaps the principles of these general measures can be summed up as follows: (1) cultivating serenity; (2) coming to terms with the inevitable; (3) living a life of moderation; (4) participating only in those affairs which one can influence; (5) avoiding fatigue; (6) having more frequent periods of rest; (7) avoiding obesity; (8) avoiding food fads and eating a well-balanced diet in small repasts; (9) selecting a physician in whom the patient can place full responsibility for wise counsel. Each of these measures requires much thought and planning, and when carried out thoroughly and systematically will add much to the comfort of life and probably conserve life itself. Administered in a cursory fashion, both physician and patient lose invaluable aids.

Excessive nervousness contributes greatly towards keeping the blood pressure elevated. Its control is often a complex problem. If, as often happens, it is associated with the female menopause, administration of stilbestrol (0.1 to 0.5 mg.) daily with meals may do much to relieve it. Occasionally, it is due to marked hyperthyroidism when it should be treated as any other case of this disease. Phenobarbital (30 mg. t.i.d.) is a generally useful sedative and may be continued for a long time if necessary. The barbiturates are very satisfactory when used under the physician's guidance for insuring adequate sleep. Other more elaborate physical methods such as Jacobson's "progressive relaxation" will not be discussed in this short review. Psychoanalysis or psychiatric guidance has its place in the treatment of some patients.

If hypertension occurs in association with one of those rare diseases such as tumor of the adrenal gland, clearly the treatment consists in removing the exciting cause. Less than three per cent of all patients will come under this category.

2. *Nephrectomy.*—If it is demonstrated that disease is limited to only one kidney, its removal has been observed in a few cases to be followed by return of the blood pressure to near normal levels. The indications for nephrectomy are unfortunately not so simple. There is no known method which demonstrates that one kidney is entirely normal and the other diseased. The impression is all too common that reduced excretory function in one kidney and normal renal excretory function in its partner constitute convincing evidence. Actually, there is no direct relationship between excretory efficiency and height of the blood pressure. Nor does there appear to be any clearly defined relation between hypertension and the appearance of the kidney as demonstrated by the pyelogram. Secondly, the conclusion has been drawn from very brief experiments in rats

that the removal of the kidney causing hypertension is usually followed by a return of blood pressure to normal. When the latter has been elevated for months or years, removal of the offending kidney is ordinarily not followed by a return to normal. Much the same seems true in human beings. So there has been in the past years a false optimism that nephrectomy would be a very important tool in the treatment of hypertensives. Perhaps this optimism is now giving way to a wave of too great pessimism.

Thus, it it is shown by x-ray examination or by kidney function tests that one kidney is obviously infected and that hypertension has developed in the past two or three years and that the other kidney seems normal, it is probably desirable to remove the offending kidney. Here, as in most situations, the indication is urological rather than medical. But if the hypertension has persisted for five years or more, if there are evidences of arteriolar sclerosis, or if the evidence for unilateral disease is uncertain, it would appear better to avoid the operation. In doubtful cases, a clearly positive family history of hypertension may be contraindication, since familial hypertension is more often "essential" than renal.

As an example of the remarkable effects nephrectomy sometimes produces in early cases of hypertension, that of MacKay, Proctor and Roome may be given. This patient underwent a pelviolithotomy and while still in the hospital the arterial blood pressure began to rise. Shortly this was followed by the signs of severe malignant hypertension. Because of the alarming course of the disease, nephrectomy was decided upon. At operation, it was found that a thick hull enveloped the parenchyma from which the kidney could be shelled out. Shortly after nephrectomy the blood pressure returned to normal and all of the signs disappeared.

In general, it is wise to view nephrectomy as a procedure which should be done when removal of the kidney would be desirable on urological grounds. Only occasionally, a patient is seen in whom abolition of the hypertension is the prime object of the operation.

3. *Potassium Thiocyanate.*—This salt has had a checkered career in the treatment of hypertension. It was introduced many years ago but fell into disrepute because of toxic manifestations occasionally observed. When Barker published a method for controlling the dosage by its level in the blood, a new wave of interest occurred. Since that time, the drug has been extensively studied. Despite this, there are two schools of thought about its value.

Many are convinced that it has a real place in the treatment of hypertensives. It lowers arterial blood pressure moderately in roughly 40 per cent of the patients and has a mild sedative effect if optimal levels of thiocyanate are reached in the blood stream. It often is a most valuable remedy for intractable headaches that afflict hypertensives. These appear to be its especial virtues.

Its drawbacks consist chiefly in the fact that it often causes a feeling of intense lassitude, of heaviness of limb. Eruptions on the skin, and more especially the mucous membranes, may occur. In older patients, mental disturbances have occasionally been encountered. Death from thiocyanate has even been recorded in the literature, but analysis of such records seems to indicate unwise judgment in the use of the drug in most of these cases. It is fair to say that death has occurred at some time from almost every drug in common use.

Our own experience with some 500 patients treated with the drug is that it is useful. We have seen only occasional patients who showed signs of its toxic action and none of them have been serious. No deaths have occurred. It has been not uncommon to see patients who were said to respond unfavorably to thiocyanate, but who, when carefully controlled, showed no toxic signs and even a favorable response.

4. *Sympathectomy.*—Dorsolumbar and splanchnic nerve resection as methods of treating patients with hypertension, just as thiocyanate, have been greeted with cheers or jeers. It is probably true that reasons intially offered for the performance of these operations were incorrect. And as a result, a flood of criticism greeted the work. Time has shown much of this to be unjustified. The field was further confused by those who attempted to transfer results obtained on animals with experimental hypertension to human beings, concluding that since in dogs these operations produced little or no reduction in arterial pressure, the same was true in man.

Probably, fortunately, sympathectomy for the treatment of hypertension developed empirically and before hypotheses were advanced to explain

it. In fact, if it had depended on some of them it might never have been practiced. Thus, it has been suggested that the effect of the operation does not depend on denervation of the vasomotor apparatus of the abdomen other than the kidneys but rather on the relief of renal ischemia. In this view, renal denervation alone should be fully effective, whereas it has no effect. Further, the view depends on renal ischemia as the efficient cause of hypertension, whereas such ischemia is not uniformly present either in experimental hypertension or in hypertension in human beings. Lastly, the operation only rarely increases renal blood flow, which is usually unchanged after an otherwise satisfactory operation. The fact that renal blood flow does not usually decrease after sympathectomy when arterial pressure has fallen, indicates that renal resistance must have diminished and, although without reference to the hypothesis of renal ischemia, it has also been suggested that this fact establishes a beneficial and specific effect of renal denervation. This point of view too is defective in that it ignores the normal autonomy of the renal circulation by which the kidney varies its resistance with arterial pressure in order to maintain as well as can be a normal rate of blood flow. There is no reason to suppose that this mechanism is in any way defective in hypertensives. Indeed, there is good evidence from the renal hemodynamic effects of high spinal anesthesia to establish its presence and within limits, normal operation. The persistence of this intrinsic renal mechanism of regulation of blood flow after operation can scarcely be attributed to denervation. Sympathectomy only leaves the kidney where it was before and its effectiveness in lowering arterial pressure is therefore largely extrarenal.

We have briefly discussed sympathectomy from the viewpoint of what has added to knowledge of the mechanism of the disease. Now we would add a word as to the usefulness of the operation. There is now no doubt that when these operations are sufficiently extensive as in the technique of Smithwick and the modified Adson procedure that marked falls in both systolic and diastolic pressures occur in some patients. This is most pronounced when the patient stands erect. Indeed, postural hypotension is one of the best indices of the completeness of the operation. The length of time blood pressure remains reduced is variable. The average is perhaps from three to five years, some less and others more.

It is not unusual for regression of the morbid changes in the eyegrounds of patients with malignant hypertension to occur. And one of the most striking changes is the loss of headaches and the regaining of a sense of well being.

One of the greatest difficulties in the application of the method has been the inability to find any single or even multiple tests which will determine whether a favorable outcome is to be expected. The hypotensive effect of administration of sodium amytal has been most extensively used to ascertain the drop in pressure to be anticipated as the result of operation. Some believe that when an adequate fall in pressure does not occur, the likelihood of success is poor, but that an adequate fall is no guarantee of success. Various authors have their own criteria and it now seems to be a matter of personal experience as to how patients are selected.

As we said before, the precise mechanism of the action of these operations is not clear. It is not improbable that several factors play a part, among these being a reduction of venous return to the heart when the patient stands erect, as a result of denervation of extensive vascular areas. Besides this, the denervation of the large splanchnic area prevents the normal reactive vasoconstriction from occuring when the patient moves from a horizontal to an erect posture. Fainting is often observed presumably because this protective mechanism has been blocked in its action.

Thus it may well be that the overall reduction of blood pressure during the 24-hour period may be quite significant and the time taken away from the destructive and sclerosing effects of the elevated pressure on the blood vessels contributed towards increasing longevity.

5. *Kidney Extracts.*—The reasons for the search for substances in the kidneys which might lower blood pressure need not concern us here. Extracts of kidneys have been prepared which lower blood pressure and cause improvement in the clinical condition of patients. But the mechanism by which these extracts act is entirely unknown.

The term "nonspecific" has been employed to describe their action. This may be true in the superficial sense of the word, i.e., the lowering of pressure is due to an unknown mechanism set into

action by a heterogeneous group of substances. Among these is fever, but many patients have fever without reduction in arterial pressure and a few vice versa. The important point to recognize is that if any form of therapy will lower blood pressure and benefit the patient, it does not make a great deal of difference what the mechanism is.

It is the belief of a very few investigators that certain types of extracts of kidneys have these beneficial effects, but none to date has been able to prepare an altogether suitable extract. Such a search is naturally a tedious and expensive job, since patients must be the test objects and nothing is known of the chemical nature of the substance sought.

There is some evidence that suggests but does not prove some degree of specificity. Kidney extract will reverse the intrarenal hemodynamic change usual in many cases of hypertension to a more normal one. Further, cardiac output will be elevated in hypertensive patients when the mean pressure falls.

It is quite clear that work along this line is still in its embryonic stage. None can foresee its outcome, hence the desirability of not attempting to codify knowledge in this field prematurely.

6. *Excessively Low Sodium Diets.*—The use of low sodium diets has recently been revived, but now the restriction is even more severe, often not more than 200 mg. of sodium being allowed in one day's diet. This level is extremely difficult to attain in most patients and is altogether impractical for some.

The results in our patients have been moderately encouraging. At least a quarter show significant fall in arterial pressure and some feel better. Administration of salt to these patients is associated with a rise in blood pressure. It appears that there is some association between the change in salt content of the diet and the height of the arterial pressure in these particular patients. Rarely, circulatory collapse occurs from the severe salt deprivation, hence the treatment has potential dangers. These can be exaggerated because most patients when not in the hospital under rigorous supervision, do not keep their salt intake below 0.5 grams.

Those of us who remember the era when low salt diets were being indiscriminately prescribed for hypertension recall that at times some lowering of pressure occurred apparently as a consequence of the low salt intake. But at that time, the intake almost never went below one gram of sodium chloride. It thus remains to be determined whether the drastic restriction now suggested is really necessary. At best, relatively few patients will be benefited from drastic salt restriction, but for these, it may well be worth the effort.

The use of amberlite resins has been suggested as a shortcut to a salt poor diet (Dock). Oral administration of certain types of these exchange resins should theoretically remove enough sodium from the intestinal juices to achieve the desired reduction in sodium balance. It is much too early to recommend their general use. It is possible that some resins may do serious damage by adsorption of other electrolytes than sodium from the gastrointestinal tract. So far, we have had reasonably good luck with them.

7. *Rice Diet.*—There are few suggestions for the treatment of hypertension that have stirred so much controversy as the rice diet. Every shade of opinion currently exists. Some see in it a cure, while others view it as deserving of nothing more than casual interest. These views are colorful, even if not based on much substantial evidence.

At present, it is not possible on the basis of published evidence to arrive at any considered opinion of its value. Many of us remember the extremes of view expressed fifteen years ago about sympathectomy. The approach, as one looks back upon it, contributed little to understanding of the nature of the problem.

The rice diet and the sodium depletion diet are alike in that each yields about 2000 calories fuel value and contains less than 0.5 gm. of sodium. They differ in their protein content, which in Kempner's regime is less than 20 gm., and in Kempner's assumption that other foods contain unidentified toxic substances not present in rice, which embarrass the kidneys.

Iu 1944, Kempner first reported on the use of the rice diet. It contains 2000 calories, not more than 5 gm. of fat, 20 g. protein, 200 mg. chloride and 150 mg. sodium, 250 to 350 gms. of rice (dry weight) is taken daily. All fruits are allowed except nuts, dates, avocados, dried or canned fruit, or fruit derivatives to which substances other than white sugar have been added. Not more than 1 banana may be taken a day. White sugar and dextrose are allowed ad libitum; on the aver-

age, a patient takes about 100 g. daily, but if necessary, as much as 500 g. may be used. Tomato and vegetable juices are not allowed. Usually no water is given and the fluid intake is limited to 700 to 1000 c.c. of fruit juice per day. Supplementary vitamins are added—vitamin A, 5000; D, 1000 units; thiamin chloride, 5 mg.; riboflavin, 5 mg.; niacinamide, 25 mg.; calcium pantothenate, 2 mg. Some form of iron is desirable. Rest in bed is neither necessary nor desirable. Weight may decrease markedly during the first 20 days.

Our own experience with the rice diet has been limited to some fifty patients. Some of them would not stay on the diet because of its monotony. Among those that did so after a prolonged control period, effects on the blood pressure have not been nearly so impressive as when the diet was started shortly after coming under our care. A fall in renal blood flow occurred in many and in a few has not seemed to be reversible. The eyegrounds of one patient may have cleared as the result of the diet, but the cause of this is uncertain. Thus, it is our view that the rice diet deserves much more careful study before its wide popularization by some of the leading clinics of the country. Our studies strongly suggest that the rice diet is essentially a low sodium diet. When blood pressure falls during its use, the addition of salt again raises pressure.

The divergent conclusions reached by different investigators lead only to conclusions that the problem is still in the investigational phase and that the investigations should be performed seriously and with every possible safeguard. One of the essential safeguards least employed is an adequate control period, and this in the face of the common experience that the level of arterial pressure may drop by 50 mm. Hg or more during the first few weeks of patient-physician contact. Casual blood pressure readings over even many years, however, do not replace as controls frequent measurements before and during the periods of dietary control. Another factor in prescribing the diet is the patient's enthusiasm for it. Very often he can only be persuaded to it by promise of relief or threats of serious complications which few physicians can conscientiously subscribe to. Still, some encouragement may be necessary, for it is only the rare patient who will take a detached and scientific view of a rigid dietary scheme.

The effects of weight loss due to the diet has not been adequately evaluated. European experience during the war would suggest that these play a much more important part in determining the decrease in arterial pressure than deprivation of animal protein and provision of protein of vegetable origin.

Finally, in the presentation of data, it should be remembered that essential hypertension is a disease with an extraordinarily variable course, so that composite curves carry little meaning or conviction. Rather, the aim should be to present well-documented studies of individual cases in which the factor of sodium loss, weight loss, hypometabolism, fluid shift and, above all, the variability of arterial pressure under control conditions are presented in detail.

8. *Rutin.*—In 1860, rutin was isolated from buckwheat, but it was not until recently that it has received clinical trial. The latter was suggested because of the similarity to vitamin P or hesperidin. It is believed by some to be effective in so-called "increased capillary fragility" in hypertension, in retinal hemorrhage, apoplexy, pulmonary hemorrhage and drug reactions.

Reports on the value of rutin are highly contradictory. In no small measure, this is due to the wide variability of the result of the various tests of capillary fragility. Indeed, at present, it seems fair to indicate that none of the tests have either been studied sufficiently carefully or the consistency of the results been demonstrated. Little or nothing is known of the natural history of increased capillary fragility.

Several authors have believed rutin prevents or cures the hemorrhages in diabetes, retinitis, and if it had the desired effect on the capillaries and if hemorrhages result from increased fragility, this would appear to offer opportunity for successful treatment. The more recent and careful articles find rutin of no value in the treatment of diabetic retinitis.

Some time ago, rutin was suggested as a treatment for hypertension, but careful study has shown it to have no significant effect on blood pressure. Griffith employed it in the treatment of a group of hypertensives in whom he believed he had demonstrated increased capillary fragility. The fragility in many cases became normal. It is not clear what, if any, effect this had on the course of the disease.

Next, rutin was used in the hope that cerebral hemorrhage might be avoided on the theory that

hemorrhage is due to capillary bleeding. There seems to be no cogent evidence that this is so. Since it is impossible with present methods to know when cerebral hemorrhage is going to occur, the problem of studying the prevention becomes one of the greatest difficulty. At present there is no reason whatever for prescribing this drug for the prevention of cerebral hemorrhage, despite drug house literature urging such indiscriminate use.

The most significant evidence that rutin has some pharmacological action comes from its use in experimental animals in preventing or reducing the hemorrhagic lesions induced in dogs by single large doses of x-rays. It may also be of some value in purpura hemorrhagica. Despite the claim that it conferred protection in anaphylactic and histamine shock, this has not been substantiated by recent work.

Clearly, the widespread sale of this material on the basis of published evidence was most unwise. The drug houses have presented only the side of the picture which makes the drug salable, rather than that showing it to be of only minor or of no value in treatment of hypertension. Unless better evidence is forthcoming, rutin has no place in the management of hypertension.

9. *Bacterial Pyrogens in the Treatment of Malignant hypertension.*—Daily administration of concentrated bacterial pyrogens, especially those from *B. prodigiosus,* over periods of weeks to months, often causes remarkable clearing of the pathologic changes in the eyegrounds of malignant hypertensives. Thus in a series of patients, average arterial pressure (systolic and diastolic, divided by 2) was reduced from a mean of 126 to 100 mm. Hg. Papilledema disappeared in all but two and fresh exudates disappeared. Improvement was also noted in the electrocardiogram and the heart size diminished.

Except for the persistent elevation of arterial pressure, remissions have lasted for an average of two years. Of the remaining nineteen patients, eleven responded more briefly, while eight showed no change. All but two of these are dead and these two are presently under treatment.

The greatest drawback in the treatment is that tolerance to the pyrogen usually appears in from five to nineteen weeks after which arterial pressure usually rose to the control levels but without reappearance of the malignant syndrome.

It has not been possible to select those patients who will respond to pyrogen therapy. Six patients who were virtually blind and four who had congestive failure responded favorably. In general, it appears that if renal excretory function is reduced by 50 per cent or more, the response will be poor, or at least more than temporary.

This treatment must be regarded as experimental until more experience has been gained. In view of the gravity of the disease, the results so far obtained justify its further use when the patient can be under the daily care of the physician.

Conclusions

Views on the nature and treatment of diseases of the circulation, arterial hypertension in particular, are rapidly changing. The pessimism of twenty years ago is giving way to the hope that with increased understanding of the mechanism of these diseases, cure may ultimately be achieved. Cure is rarely achieved today, but much can be done to ameliorate the disease.

The pathogenesis of hypertensives remains unsolved, but investigation is actively being pursued in the two principle theories, namely: (1) the occurrence of circulating pressor agents such as angiotonin; (2) the occurrence of increased vasomotor activity. The fusion of those two seemingly diverse beliefs may well occur.

Treatment must cover a wide variety of signs or symptoms because blood vessels are affected in most parts of the body. No highly specific remedies which will lower blood pressure are available but the discerning use of several agents leads to far greater comfort for the patient and doubtless in many cases to prolongation of life.

MSMS

Brain tumors are missed mainly because of sketchy neurologic history and examination and false evaluation of personality disorders, seizures, headaches and eye signs.

* * *

About 50 per cent of ureteral stones are passed within a week of the first symptoms; some may remain in the ureter as long as three years without harm.

* * *

Are you prepared? Did your college prepare you? Are your Medical Society programs helpful?

* * *

No medical examination is complete unless the psychological aspects are respected.—MSMS Mental Hygiene Committee

Anticoagulant Therapy in Heart Disease

With Particular Reference to Its Use in Congestive Failure

By Ivan F. Duff, M.D., and
James W. Linman, M.D.
Ann Arbor, Michigan

USEFULNESS of anticoagulants in heart disease has been appreciably extended by investigations carried out in the last three years. In particular, the value of heparin and dicumarol appears to have been well established in the treatment of acute myocardial infarctions. Their effectiveness as prophylactic agents is being demonstrated in the patient in congestive failure and the individual with rheumatic heart disease and auricular fibrillation subjected to showers of systemic and pulmonary emboli. We are becoming aware, too, of the protection which they may afford to the individual with an impending myocardial infarction or who has already survived one or more such catastrophes.

Treatment of Acute Myocardial Infarctions

The praiseworthy accomplishments of the Committee of the American Heart Association for the Evaluation of Anticoagulants in the Treatment of Coronary Thrombosis with Myocardial Infarctions are well known. One thousand and thirty-one cases were involved in this co-operative study: 442 of these receiving "conventional therapy" constituted the "control group"; 589 receiving anticoagulants in addition to conventional therapy constituted the "treated group." Several conclusions were drawn from the accumulated data.[24]

It was apparent that the death rate and incidence of thromboembolic complications in the group receiving anticoagulants were markedly lower than among patients treated by conventional methods; indeed, somewhat more than one-third of the subjects who would have died without anticoagulant therapy survived the specific attack under consideration. Reduction of thromboembolic complications was the main factor in reducing the death rate. Patients 60 years of age or older received the greatest benefit in reduction of mortality. The crude death rates for younger patients in both the treated and untreated groups did not show a significant difference; the incidence of thromboembolic complications, however, was decidedly lower in the treated group.

The study demonstrated that although the incidence of thromboembolic complications, like that of death, was highest in the second week, it was marked throughout the first four weeks. Because it is impossible to predict which patient will suffer a thromboembolic complication, it is therefore important to give anticoagulant therapy to all patients with a myocardial infarction provided such treatment can be safely and effectively controlled. Treatment should be instituted as late as the second or third week or even later if complications occur. The hemorrhagic complications were so mild and so few and the benefits of treatment in the older age group were so pronounced that the committee did not hesitate in prescribing anticoagulants for the older patients.

The committee recommended that treatment, to give maximum protection, be employed for at least four weeks after the last thromboembolic complication. This is the ideal. Actually, in our experience, economic reasons not infrequently force us to regard three weeks as adequate treatment during the last few days of which the patient is made ambulatory.

The objectives which one hopes to attain with anticoagulants after a myocardial infarction are: (1) prevention of venous thrombosis in the peripheral veins and the occurrence of pulmonary infarctions; (2) prevention of secondary myocardial infarctions either by the extension of the thrombus within the coronary artery or by the development of infarctions in new areas in the myocardium during the period of convalescence; (3) prevention of the development of mural thrombi and thereby the development of pulmonary, cerebral and peripheral emboli; (4) prevention of concomitant arterial thromboses in the brain, lungs, etc. In this co-operative study one or more thromboembolic complications occurred in 11 per cent of the treated patients; only six per cent, however, occurred while under the full effect of anticoagulant therapy. One or more thromboembolic complications occurred prior to death in three per cent of the treated group. These figures emphasize that in individual cases any one of the above complications may sometimes occur with a lethal

From the Department of Internal Medicine, University of Michigan, Ann Arbor, Michigan. This investigation was made possible by grants from the Horace H. Rackham School of Graduate Studies, The Charles Baird Research Fund for Internal Medicine and by the generosity of S. R. Light, M.D., of Kalamazoo, Michigan.

outcome despite the early institution of energetic treatment.

It is oftentimes difficult to be immediately certain of the diagnosis of a myocardial infarction. Again, in some instances, the clinical findings may be at variance with the electrocardiographic changes. In these circumstances the most conservative plan of management is to proceed with the anticoagulants. If the diagnosis is later disproved, the treatment may be stopped. The decision as to whether heparin should be employed oftentimes arises. We are inclined to agree with Hines and Barker that treatment with dicumarol alone, were it started within the first forty-eight hours, would probably afford adequate protection in the majority of instances.[10] As they point out, however, such treatment would not prevent the extension of the thrombotic process in the coronary vessels or intramural thrombosis during the period of shock which often occurs early in the illness. Moreover, as Schilling notes, if one counts the delay associated with establishment of diagnosis and the period of time required for dicumarol to become effective, a period of four to five days may easily elapse before effective treatment is achieved. In addition, the development of congestive failure further favors the development of thromboembolism.[20] For these reasons the early administration of heparin, in addition to the starting of dicumarol, seems advisable.

Definite contraindications to heparin, dicumarol or tromexan may exist after a myocardial infarction, as in a patient with a potential or actual hemorrhagic condition or concurrent severe renal or hepatic disease. The most important contraindication, however, to the use of dicumarol and tromexan is lack of adequate laboratory or clinical control.[5] In patients treated in the home and in the smaller hospital, this constitutes a real problem. Under these circumstances the depository heparin preparations may be of special value. Although they are sometimes painful and quite expensive, their administration, controlled by the simple Lee and White test performed at the bedside, is entirely possible for periods of ten to fourteen days or even longer.[15]

Chronic Administration of Anticoagulants to Prevent Recurrent Myocardial Infarctions

Appreciation of the effectiveness of the anticoagulants in acute myocardial infarctions led Nichol at an early date to investigate their protective value in the patient who has already sustained one or more infarctions.[19] His series now consists of seventy-eight cases, treated from three to sixty-two months; thirty-three of these had experienced more than one attack of coronary thrombosis. Twelve died while under treatment. In four, death was due to recurrent attacks of coronary thrombosis; in six, it was ascribed to either acute coronary insufficiency, congestive heart failure or "cessation of cardiac activity" (probably ventricular fibrillation or ventricular standstill). Cerebral hemorrhage was the cause of death in two patients. Autopsies were performed in eight, revealing fresh coronary thrombosis or infarction in three. No mural thrombi or other complicating thromboembolic manifestations were found. He also observed that the patients experienced significantly fewer subjective complaints of cardiac pain while taking dicumarol, it being minimal or absent in nearly all of 57 moderately active patients on sustained treatment. The recent work of Gilbert et al, suggesting that dicumarol increases coronary volume flow by a strong dilating effect is of interest in this respect.[7] Other alterations in blood properties associated with the dicumarol effect, now poorly understood, may be responsible for this improvement.[19]

The chronic administration of dicumarol to ambulatory patients is frequently associated with an appreciable incidence of bleeding episodes. The difficulty of drawing conclusions as to the efficacy of such treatment is quite obvious when it is recalled that it is impossible to predict which patients will have but a single myocardial infarction and which will have repeated episodes. It is obvious also that the regime, even when carefully followed, may fail to prevent myocardial infarctions. Despite these and other disadvantages, the venture appears well worth while in selected individuals. In four patients treated by us in this manner from four to nineteen months, angina has become less severe and less frequent; gradual return to gainful employment has been possible.

Anticoagulants in the Treatment of Impending Myocardial Infarctions

Closely allied to the preceding topic is the use of anticoagulants in acute coronary insufficiency or impending myocardial infarctions. Consideration of this occurred to Nichol and his co-worker during their studies to which previous reference has

been made. We are all familiar with the individual whose symptomatology, chiefly that of angina, suggests acute embarrassment of the coronary vessels and yet in whom the diognostic criteria for a myocardial infarction have not been fulfilled, or must await serial electrocardiograms. The problem in these individuals, as Nichol points out, is immediate therapy.[18] With the anticoagulants we now have an incentive for the early detection and treatment of impending myocardial infarctions. Heparinization, in particular, appears indicated in these individuals as soon as the diagnosis is made; it is usually administered with dicumarol.

As far as is known, report of but one study has been published concerning a group of 41 such patients.[18] A fair degree of relief from anginal pain was obtained in all but three patients. In many cases relief of pain was prompt and striking after heparinization was achieved. There were no deaths in the entire group while anticoagulants were in force. Only two of the forty-one developed transmural myocardial infarctions after anticoagulants were started. Twenty-four patients developed clinical signs of subendocardial necrosis. Of the eighteen patients who received anticoagulants for a short term of treatment, four died with acute myocardial infarctions seven days, fourteen days, two months and ten months after stopping dicumarol. In a fifth patient an acute, non-fatal infarction occurred ten days after a short term course of dicumarol was stopped. The need for further investigation of the benefits of anticoagulants in this particular field is obvious.

Anticoagulants as Prophylaxis Against Thromboembolism in Congestive Heart Failure

A number of studies have demonstrated the frequency of thromboembolic complications in heart failure. Kinsey and White, searching for the cause of fever in 200 cases of congestive failure, reported pulmonary infarctions in twenty-four out of fifty autopsied cases.[12] Carlotti, et al, studied 273 patients with pulmonary embolism in 194 of whom the clinical admitting diagnosis was congestive failure.[3] Wishart and Chapman believe the figure 22 per cent approximates the true incidence of pulmonary infarcts in patients with congestive heart failure, not all of whom die.[21] The mortality, however, associated with pulmonary infarctions is greater in patients with heart disease (irrespective of the presence of congestive failure) than in patients without heart disease.[13]

As others have emphasized, an important discrepancy exists between the frequency with which thromboembolism is recognized in life and its true incidence as observed in the necropsy room. At the Massachusetts General Hospital patients with pulmonary infarctions were studied during two five-year periods (1936-1940 and 1941-1945). The diagnosis was made correctly in the first group in 33.3 per cent and 60 per cent in the second series.[3] We obviously need to become more aware of the danger of thromboembolic complications in patients with heart disease. In addition to this it should be emphasized that but little has been done to reduce the incidence of venous thrombosis and embolism in this group. At the University of Michigan Hospital the incidence of pulmonary embolism among non-cardiac patients has declined, in an eight-year period, from 169 cases in the control period of 1940-1943 to fifty-three cases in the years 1944-1947. The incidence, however, in patients with heart disease has remained virtually unchanged, being forty-one cases (of which twenty-four were fatal) in the control period and 44 cases (of which thirty-seven were fatal) in the second period.[14]

The possibility of altering the frequency and gravity of thromboembolism in patients with heart disease, and particularly in congestive failure, has been explored by two different approaches. Homans, representing the surgical point of view, recommended vein ligations to reduce the incidence and mortality associated with thromboembolism in heart disease.[9] Carlotti, et al, reported a mortality rate of 28.3 per cent in a group of sixty treated by ligation, contrasted, in a control group of 215 cases treated without ligation, with a mortality rate of 50.7 per cent.[3]

The first report of the use of dicumarol as an adjunct to the treatment of congestive heart failure was made by Anderson and Hull in November, 1947.[1] Sixty-one patients were treated with dicumarol in addition to the conventional treatment. Fifty-eight patients receiving only conventional therapy constituted the control group. The mortality rate was 11 per cent in the treated group and 18 per cent in the control group. In the treated group of patients there were five instances of thromboembolism which may have played a part in 2 deaths. In the control group there were nine instances of thromboembolism

which may have played a part in the death of seven patients. They observed that the mortality was lower and the apparent incidence of thromboembolism was less in the group of patients who received dicumarol. They could not, however, be certain that the difference in mortality was significant or that the apparent difference in incidence of thromboembolic complications was real. More recently Hull has stated: ". . . We have during the past two years been carrying on a controlled study on the use of dicumarol in patients with congestive heart failure, a series now running well over 300 cases. A significant reduction of mortality has occurred, which can be attributed to the practically complete absence of thromboembolic complications in the treated group."[11]

A preliminary report of a similar investigation was made by Wishart and Chapman in November, 1948.[21] They administered dicumarol to all patients (61) hospitalized because of congestive failure; a control series in the same hospital was not studied. The mortality rate was 38.2 per cent (twenty died); there were 12 necropsies. The incidence of pulmonary infarctions during effective dicumarol therapy was 6.5 per cent. No deaths could definitely be attributed to classic pulmonary embolism; one death might have been due to such a condition. One patient developed a venous thrombosis at a time when dicumarolization was adequate; in two patients in whom it was not adequate, definite pulmonary infarctions occurred.

Harvey and Finch have recently reported their studies in a group of patients with congestive heart failure; dicumarolization was carried out depending on whether their hospital admission was on an even or an odd day; there were eighty patients in the treated group and 100 in the control group.[8] Patients with a history or findings suggestive of thromboembolic disease at the time of admission were excluded from both series. They did not include patients dying within forty-eight hours and patients in failure because of acute myocardial infarctions. The groups were similar as to type of heart disease, age distribution and severity of congestive failure. In the control group the total mortality was 17 per cent; there were thirteen pulmonary emboli, eight of which were proven at autopsy; in addition there were two questionable cases; there were eight cases of thrombophlebitis. In the treated group the mortality was nine per cent; none of the deaths were believed to have been due to pulmonary embolism. There were two questionable cases of pulmonary emboli; there was one definite case of thrombophlebitis and one questionable case.

A pilot study to evaluate the effectiveness of prophylactic dicumarolization in congestive failure before thromboembolism has occurred has been under way at the University of Michigan Hospital. A study plan was used similar to that outlined by Harvey and Finch. There were thirty-one patients in the "treated group." In a control group of thirty-two patients, thirteen died (40 per cent); there were twelve autopsies. Nine patients sustained pulmonary infarctions, five of which were proven at autopsy; there were three cases of proven peripheral venous thrombosis. Of the entire control group, fourteen sustained some type of a thromboembolic phenomena; 18 escaped this catastrophe. Three (9.7 per cent) died in the treated group; there was 1 autopsy. None died of thromboembolic complications. A probable massive cerebral hemorrhage, perhaps to be associated with treatment, was fatal in one case. There were two patients who sustained definite pulmonary infarctions, despite effective prothrombin levels, both eventually recovered. Clinical evidence of peripheral venous thrombosis was not present in these patients. Of the entire treated group, two sustained some type of thromboembolism; twenty-nine escaped this complication.

Although the total number of patients treated with prophylactic anticoagulants is small in the quoted series, the results appear sufficiently encouraging to justify further exploration. In this regard it may be stressed that, in our experience, the benefits of anticoagulant therapy are less obvious once a patient with congestive failure has sustained a pulmonary infarction. In an earlier study of a group of twenty-five cardiac patients, none of whom are included in the above series, eighteen had sustained pulmonary emboli before treatment with anticoagulants was instituted; in eight, this appeared to have occurred at least a week prior to hospitalization after which confusion of the clinical picture frequently further delayed treatment. Twelve of the group died. Despite effective reduction of the prothrombin, recurrent pulmonary infarctions occurred in twelve from which two survived. On the basis of this experience, it appears that if anticoagulants are to effectively protect the patient in congestive failure, they must be instituted early and prior to the onset of thromboembolism.

The employment of anticoagulants in the presence of heart failure should be carried out with some caution. The existing evidence indicates that in some individuals heart failure may be associated with a lowered prothrombin activity and increased sensitivity to dicumarol. Out of thirty patients described above, pretreatment prothrombin levels were 50 per cent or less of normal concentration in seven. Under these circumstances, then, one should guide dicumarol dosage in the knowledge of the pre-treatment prothrombin level. A second point of some interest concerns the use of dicumarol in a patient with severe hypertension, particularly if the individual has sustained a cerebrovascular accident in the past.[5,16] Unusual sensitivity to dicumarol and associated fatal cerebral hemorrhages have been observed under these circumstances. By way of contrast, Nichol questions whether hypertension exaggerates the risk of cerebral hemorrhage during anticoagulant therapy.[17]

Long-term Anticoagulant Therapy in Patients with Recurrent Systemic Emboli

The use of prophylactic long-term anticoagulant therapy in patients with old rheumatic heart disease complicated by valvular damage, auricular fibrillation and showers of systemic peripheral emboli was first reported by Wright in 1947.[22] Since that time further encouraging reports have appeared.[2,4,6,23] About sixty patients are involved in these series, in some of whom treatment has been carried out for as long as three years.

Several points of interest arise in the selection of patients for such treatment. It is said that only between four and eight per cent of patients with rheumatic heart disease and mitral stenosis ever experience emboli. The occurrence of auricular fibrillation appears to increase the occurrence of intracardiac thrombi about threefold. The interval, however, between the onset of fibrillation and embolic episodes is unpredictable. With these facts in mind it seems clear that the presence of rheumatic heart disease with mitral stenosis and normal rhythm is not in itself sufficient to justify institution of long-term anticoagulant therapy. Whether or not one is justified in undertaking such treatment with the advent of auricular fibrillation, or soon after its appearance, is controversial. The development, however, of congestive failure in such a patient, with its increased tendency to intravascular clotting, would encourage one to institute treatment.

Once embolization has occurred, the indications for long-term treatment are more definite since there is no means by which the occasional patient who will suffer repeated attacks of recurrent emboli may be identified. It appears to us that the same reasoning may be applied in selecting for treatment the patient with non-rheumatic heart disease and auricular fibrillation and in whom systemic or pulmonary emboli have occurred.

Once the patient and physician have committed themselves to the decision of instituting chronic anticoagulant therapy, the question will arise as to how long it should be continued. There is, at the present, no answer. Careful perusal, however, of the fascinating case reports published by different observers may be helpful in this respect. Wright, for instance, has stated: ". . . Patients who have had as many as twelve and even twenty emboli have ceased having emboli and in the six treated for more than one year (one nineteen months) no emboli have occurred."[23] Such reports and personal experience appear to indicate that the therapy has brought about a decrease of the expected incidence of thromboembolism. The relationship, moreover, between the sometimes rather prompt development of further thromboembolic episodes and cessation of treatment appears reasonable. In view of this, treatment, if successful, may well be continued for an indefinite time; perhaps for the remainder of life or until some other more satisfactory approach is available.

In evaluating the effect of therapy in any specific case, one should recall that it is not unusual for several months or years to elapse between embolic episodes. It may be recalled, too, that the anticoagulants are not always effective in suppressing intravascular clotting. In an occasional individual the clotting tendency may be more powerful than the anticoagulant effect of dicumarol or heparin. This, together with fragmentation of pre-existing mural thrombi, may explain embolic episodes occurring despite theoretically effective reduction of prothrombin activity. Notwithstanding the occurrence of these occasional failures, the institution of protracted anticoagulant therapy in these unfortunate individuals appears to be worth while provided, of course, it can be done safely and effectively.

Summary and Conclusions

It is our opinion that all cases of acute myocardial infarction should receive heparin and

dicumarol provided circumstances permit their safe and effective control. On the basis of personal experience, and the recorded observations in the literature, it is our tentative impression that the usefulness of the anticoagulants may be extended to other fields of heart disease. Dicumarolization to reduce the incidence and mortality associated with thromboembolism appears to be a useful adjunct to the conventional treatment of patients in congestive heart failure. The incidence of thromboembolism is described in a small controlled series of patients in congestive failure receiving prophylactic dicumarol. Long-term administration of anticoagulants appears to offer distinct advantages to the individual threatened by an impending myocardial infarction or who has already sustained recurrent infarctions of the heart. Prophylactic, long-term treatment appears to offer some protection to the individual with auricular fibrillation and recurrent systemic or pulmonary emboli.

Heparin, dicumarol and tromexan are not perfect therapeutic agents. Adequate clinical and laboratory control is essential for safe and effective administration of these drugs. The principles of management now well defined by clinical experience, and described in detail elsewhere, remain largely the same regardless of the indications for their use. Their employment in heart disease sometimes implies prolonged administration to ambulatory patients. The effectiveness, and certainly the safety of such treatment, requires close co-operation between an intelligent patient, a conscientious physician and readily available and reliable laboratory facilities.

Bibliography

1. Anderson, G. M., and Hull, E.: The use of dicumarol as an adjunct to the treatment of congestive heart failure: results in a controlled series of sixty-one cases. South. M. J., 41:365-371, (Apr.) 1948.
2. Askey, J. H., and Cherry, C. B.: Thromboembolism associated with auricular fibrillation. J.A.M.A., 144:97-100, (Sept. 9) 1950.
3. Carlotti, J., Hardy, I. B., Jr., Linton, R. R., and White, P. D.: Pulmonary embolism in medical patients, comparison of incidence, diagnosis and effect of treatment in two hundred and seventy-three cases at the Massachusetts General Hospital in two five-year periods (1936 to 1940 and 1941 to 1945 inclusive). J.A.M.A., 134:1447-1452, (Aug. 23) 1948.
4. Cosgriff, S. W.: Prophylaxis of recurrent embolism. J.A.M.A., 143:870-872. (July 8) 1950.
5. Duff, I. F.: Effectiveness of anticoagulant therapy as observed in 300 cases. Angiology, 1:170, (April) 1950.
6. Foley, W. R., and Wright, I. S.: Long term anticoagulant therapy for cardiovascular disease. Am. J. M. Sc., 217:136-142, (Feb.) 1949.
7. Gilbert, N. C., Fenn, G. K., and Nalefski, L. A.: Role of vasodilator drugs in coronary occlusion. J.A.M.A., 141:892-894, (Nov. 26) 1949.
8. Harvey, W. P., and Finch, C. A.: Dicumarol prophylaxis of thromboembolic disease in congestive heart failure. New Eng. J. Med., 242:208-211, (Feb. 9) 1950.
9. Homans, J.: Operative treatment of venous thrombosis in the lower limbs. Am. J. Med., 3:345-354, (Sept.) 1947.
10. Hines, E. A., Jr., and Barker, N. W.: Anticoagulant therapy in cardiovascular diseases. M. Clin. North America, 33:335-345, (March) 1949.
11. Hull, E.: Letter to Editor, Modern Med., p. 102, (Nov. 15) 1949.
12. Kinsey, D., and White, P.: Fever in congestive failure. Arch. Int. Med., 65:163-170, (Jan.) 1940.
13. Krause, G. R., and Chester, E. M.: Infarction of the lung—a clinical and roentgenologic study. Arch. Int. Med., 67:1144-1156, (June) 1941.
14. Lillie, R. H., Buxton, R. W., and Duff, I. F.: Prevention and management of thromboembolism. Arch. Surg., 59:609-632, (Sept.) 1949.
15. Linman, J. W., Duff, I. F., and Serfontein, S.: Anticoagulant therapy with depository heparin. U. Michigan M. Bull., 16:69-73, (March) 1950.
16. London, R. E.: Dicumarol fatality in severe hypertensive and arteriosclerotic cardiovascular disease despite controlled therapeutic level. Circulation, 1:1205-1208, (May) 1950.
17. Nichol, E. S.: The risk of hemorrhage in anticoagulant therapy. Ann. West. Med. & Surg., 4:71-81, (Feb.) 1950.
18. Nichol, E. S.: The use of anticoagulants in acute coronary insufficiency or impending myocardial infarction. South. M. J., 43:565-574, (July) 1950.
19. Nichol, E. S., and Borg, J. F.: Long-term dicumarol therapy to prevent recurrent coronary artery thrombosis. Circulation, 1:1097-1104, (May) 1950.
20. Schilling, F. J.: Anticoagulants in myocardial infarctions. J.A.M.A., 143:785-789, (July 1) 1950.
21. Wishart, J. H., and Chapman, C. B.: Dicumarol therapy in congestive heart failure. New Eng. J. Med., 239:701-704, (Nov. 4) 1948.
22. Wright, I. S.: The use of anticoagulants in the treatment of diseases of the heart and blood vessels. Trs. and Stud. Coll. Physicians, Philadelphia, Series 4, 15:15-17, (Apr.) 1948.
23. Wright, I. S.: The use of the anticoagulants in the treatment of diseases of the heart and blood vessels. Ann. Int. Med., 30:80-91, (Jan.) 1949.
24. Wright, I. S., Marple, C. D., and Beck, D. H.: Report of the Committee for the Evaluation of Anticoagulants in the treatment of Coronary Thrombosis with Myocardial Infarction. Am. Heart J., 36:801-815, (Dec.) 1948.

MSMS

RHEUMATIC HEART DISEASE

(Continued from Page 1410)

in a busy day to listen patiently to the story of vague symptoms and signs. It is only by piecing together many little things that a real and main diagnosis will finally appear. He must be able to watch the progress of those symptoms and signs so that when they disappear under his care he will not, from fear or indecision, continue the restrictive measures too long.

Since rheumatic fever has its highest incidence in families with low income, insufficient to care for a long-time chronic illness, inadequate facilities and low understanding or interest in health situations, a community must provide hospital service for the severely ill patient and specialized clinic service for follow-up examination, evaluation and consultation. Joint co-operation between physician, clinic and hospital, and community program will serve to diagnose and control rheumatic fever.

References

1. American Academy of Pediatrics, Transactions: A statement to guide school health authorities. Pediatrics, 2:321, 1948.
2. Friedman, S., and Harris, T. N.: Apical diastolic heart sounds in active rheumatic fever. Pediatrics, 3:603, 1949.
3. Friedman, S., Robie, W. A., and Harris, T. N.: Occurrence of adventitious cardiac sounds in childhood. Pediatrics, 4:782, 1949.
4. Harris, T. N., Friedman, S., and Haub, C. F.: Phonocardiographic differentation of murmurs of mitral insufficiency from some commonly heard adventitious sound in childhood. Pediatrics, 3:845, 1949.
5. Jones, T. D.: Diagnosis of rheumatic fever. J.A.M.A., 126: 481, 1944.
6. Levine, S. A., and Harvey, W. P.: Clinical Auscultation of the Heart. Philadelphia: W. B. Saunders Co., 1949.

Treatment of Congestive Failure Refractory to the Standard Regimen

By Gordon B. Myers, M.D.,
Harper K. Hellems, M.D.,
Lloyd T. Iseri, M.D.,
and
Albert J. Boyle, M.D.
Detroit, Michigan

THE FIVE BASIC therapeutic measures for congestive failure; namely, rest, salt restriction, digitalization, diuresis and mechanical removal of fluid, have been in use for many years. Modern pharmacological research has introduced pure cardiac glycosides as an alternative for digitalis leaf and effective mercurials to replace the more toxic merbaphen, but has not as yet made any fundamental advance. In fact, the modern trend in therapy has been toward the employment of a standardized dosage of digitalis and mercurials in all cases. Although a stereotyped regimen succeeds in restoring compensation to the majority of patients, a significant minority fails to respond and is unjustifiably considered refractory. Most patients who remain in congestive failure after the standard regimen will regain compensation if treatment is individualized with due regard to their disturbed physiological state. The purpose of this communication is to discuss the physiological factors that may be responsible for apparent refractoriness and to emphasize the application of accepted therapeutic principles in their correction.

The refractory cardiac patient should, therefore, be reevaluated with the following questions in mind:

1. Have etiological factors amenable to specific therapy been overlooked?
2. Has adequate rest been provided?
3. Has sodium been restricted sufficiently?
4. Has the optimal effect of digitalis been obtained?
5. Has optimal use been made of diuretics?
6. Have serous effusions, preventing restoration of function, been aspirated?

From the Department of Medicine of Wayne University College of Medicine and Detroit Receiving Hospital.
This work was supported, in part, by grants from the Michigan Heart Association and the National Heart Institute.

Have Etiological Factors Amenable to Specific Therapy Been Overlooked?

An accurate etiologic, anatomic and physiologic diagnosis is essential to the intelligent management of congestive failure. In the survey of the refractory patient, conditions that may be mistaken for cardiac failure, such as cirrhosis, nephrosis, vena caval obstruction, scleredema, etc., should first be excluded. Then particular attention should be directed toward the recognition of the following primary and contributory factors, for which specific therapy is available.

Correctable Mechanical Defects.—Many congenital abnormalities capable of producing intractable congestive failure, such as patent ductus arteriosus, pulmonic stenosis and coarctation of the aorta, may be cured or at least improved by modern cardiac surgery.[5,8,12,18,19] In chronic rheumatic valvular disease, failure due chiefly to mechanical obstruction of an orifice (e.g. marked mitral stenosis or aortic stenosis) must be distinguished from failure due chiefly to a myocardial lesion, since the former may be alleviated by commissurotomy.[1] Tamponade from pericardial effusion or constrictive pericarditis must be recognized because of the cure or improvement effected by paracentesis in the former and surgical stripping of the epicardium in the latter.[10] Rare defects amenable to surgery, such as arteriovenous aneurysm, should not be overlooked as a cause or contributory factor in congestive failure.[22]

Endocrine, Metabolic and Nutritional Factors.—Diseases necessitating increased cardiac output and work, such as hyperthyroidism, beriberi and anemia, may be responsible for refractory failure in patients with underlying heart disease. Hyperthyroidism is easily overlooked in the cardiac patient because of the frequent absence of the characteristic facies and eye signs.[27] The presence of good appetite, unusual alertness, heat intolerance, warm palms, uncontrollable tachycardia, increased pulse pressure or an enlarged nodular gland should lead to an investigation for hyperthyroidism and, if the diagnosis is confirmed, to specific treatment. The suspicion of beriberi should be aroused by a history of dietary inadequacy, as in chronic alcoholism, by the development of edema prior to dyspnea, by clinical evidence of avitaminosis, together with physical signs referable to increased cardiac output; the diagnosis is confirmed by the specific response of

the cardiac manifestations to thiamin.[14] Anemia, though usually recognized, is frequently neglected in the treatment of the refractory cardiac patient. If edema in the cardiac patient proves refractory to the standard regimen, the possibility of complicating factors, such as myxedema or hypoproteinemia, must receive consideration and specific treatment.

Underlying or Intercurrent Infection.—Acute myocarditis due to rheumatic fever, subacute bacterial endocarditis, diphtheria and other infections must be recognized and receive specific treatment when such is available. Fever due to infection elsewhere in the body should be controlled as promptly as possible in decompensated patients because of the fact that it contributes to the failure by increasing cardiac work.

Underlying or Associated Pulmonary Disease.—Bronchial and pulmonary infections in patients with left-sided failure contribute to pulmonary congestion and must receive symptomatic and specific treatment. Pulmonary embolism and infarction are often responsible for refractoriness to therapy in patients with congestive failure due to other causes. Prevention of future embolism by anticoagulants or venous ligation proximal to the thrombus is essential to recovery. Chronic obstructive pulmonary emphysema may eventually give rise to cor pulmonale and congestive failure, that may be helped by mechanical measures causing elevation of the diaphragm.[11]

Acute Myocardial Infarction.—Acute myocardial infarction may be responsible for intractable failure and should be recognized because of the value of anticoagulants and the precaution to be taken in the use of digitalis.

Assuming that the foregoing possibilities have been investigated and adequately treated, persisting congestive failure demands attention to the following measures.

Has Adequate Rest Been Provided?

The patient in congestive failure has an inadequate cardiac output for his metabolic needs.[29] These resolve themselves into basal metabolic requirements, which are virtually irreducible,* and demands of activity, which can be controlled. The failing heart is unable to meet the stress of exercise by a sufficient increase in cardiac output.[21] The kidneys respond by enhanced tubular reabsorption of sodium and water,[9,32] and reduced blood flow,[30,31] leading to an increase in blood volume and a rise in venous pressure. Continued physical activity above the patient's capacity establishes a vicious cycle of progressive sodium and water retention, increasing blood volume and venous pressure, and consequent passive congestion and edema of the pulmonary and systemic circuits. To break this vicious cycle, restriction of activity within the limits of the patient's reduced cardiac output is obligatory.

When congestive failure is refractory to the standard regimen in the home, hospitalization is required to order to provide maximal rest, as well as accurate control of diet and medication. The cardiac patient obtains more rest in the sitting than in the recumbent position because recumbency promotes shift of blood from systemic to pulmonary circuits, further reducing vital capacity and increasing respiratory effort and cardiac work.[26] Maximal rest is obtained during the day in a large chair, suitably supported by pillows, and at night in a bed supplied with head blocks of six to nine inches and a back rest for elevation and support of the trunk and head. Rest in this manner not only decreases cardiac work, but also tends to prevent the complications of phlebothrombosis, pulmonary embolism and bronchopneumonia, which are all too frequent in the cardiac patient strictly confined to bed. To further promote rest, the patient should use a commode by the bedside rather than a bedpan or the bathroom. Efforts to secure emotional rest by judicious sedation, elimination of disturbing visitors and provision of pleasant nursing care, combined with the foregoing measures to achieve physical rest, will place the patient in the optimal condition for recovery of cardiac functional competency.

Has Sodium Been Restricted Sufficiently?

Most of the incapacitating symptoms of heart failure result from congestion and edema of the lungs, abdominal viscera and extremities. Accumulation of edema fluid in heart failure is dependent upon increased retention of sodium by the kidneys.

Mere abstention from salty food and elimination of salt in cooking and at the table may not suffice in the more severe cases. The advantage of a low sodium intake without drastic dietary restriction

*Although basal requirements may be reduced by thyroid ablation, through total thyroidectomy or radio iodine,[6] so drastic a measure should be reserved for patients refractory to all other forms of therapy.

can be gained by the administration of cation exchange resins, which interfere with the absorption of sodium from the alimentary tract.[25] Unfortunately, these resins also interfere with the absorption of potassium and calcium and may produce severe hypokalemia or hypocalcemia. For these reasons, these resins are not advisable unless facilities are available for frequent determinations of blood potassium and calcium.

The time-honored Karell regimen, consisting of 800 ml. of whole milk daily, enabled many patients to regain compensation, but failed in the more severe cases because of insufficient limitation of sodium intake (400 mg.), and too drastic a restriction in water and other essential ingredients. Greater success has been obtained with modern cardiac diets, supplying 200 to 400 mg. sodium daily, but refractory cases of severe congestive failure are still encountered. As long as sodium is restricted, the patient should be urged to take a total of 2.5 to 3.0 liters of fluid daily, but no advantage is gained from forcing fluids above this level.

A diet restricted to 50 mg. sodium daily, but furnishing adequate water, potassium, chloride, protein and total calories, is recommended as a temporary expedient in severe congestive failure, particularly when refractory to the standard regimen.[23] The diet consists of 2000 ml. of Lonalac formula and 500 ml. of orange juice with 30 gm. of added sugar. It is made adequate in vitamins by the use of crystalline supplements. The Lonalac formula is prepared as follows: Lonalac powder, 250 gm.; sugar, 125 gm.; and water, 2000 ml. The formula is mixed well into an even suspension, flavored with vanilla and kept chilled; 400 ml. of this are given five times a day. Orange juice, 250 ml., is given two times daily.

Congestive failure, refractory to bed rest, a low sodium diet, digitalization and mercurial diuretics, carried out in the hospital for from one to several weeks, has shown dramatic improvement following institution of this 50 mg. sodium diet, without other change in the therapeutic regimen.[23] Relief of pulmonary congestion and edema was particularly striking during the administration of this diet. Restriction of sodium intake to 50 mg. daily is seldom needed for more than one week and, as long as compensation is maintained, a gradual step-like increase may be made to a maximum of approximately one gram.

The diet should furnish adequate potassium, since metabolic studies have demonstrated that large quantities of this element are taken up by the cells during recovery from congestive failure, presumably to replenish a deficit. The only exception to a liberal potassium intake is the presence of anuria or severe oliguria, which may lead to potassium intoxication.

Has the Optimal Effect of Digitalis Been Obtained?

Digitalis increases the force of systolic contraction in the dilated failing heart.[28,37] Therapeutic doses, given to decompensated patients with rapid, regular sinus rhythm, cause a primary augmentation of cardiac output, permitting a secondary fall in rate. Digitalis has an even more dramatic effect in congestive failure accompanied by auricular fibrillation because it not only improves ventricular contractility, but also specifically reduces ventricular rate by depression of conductivity through the atrioventricular node. The improvement in cardiac output is followed by rise in renal blood flow and glomerular filtration, increase in urinary excretion of sodium, chloride and water, evacuation of pulmonary and peripheral edema, relief of dyspnea, reduction in circulating blood volume and fall in venous pressure.

The refractory patient is generally receiving digitalis in some form when he comes under consideration. The first problem is to determine whether the degree of digitalization is inadequate, optimal or excessive. The differentiation between underdigitalization and overdigitalization is complicated by the fact that the familiar gastrointestinal symptoms of digitalis intoxication, namely, anorexia, nausea and vomiting, may also occur as a manifestation of inadequately treated passive congestion of the abdominal viscera, whereas the early cardiac signs, namely, premature beats and bigeminy, may be found in association with untreated cardiac decompensation. The presence of these symptoms and signs at the advent of digitalis therapy, the lack of temporary mitigation and failure to induce diuresis or relieve dyspnea would indicate underdigitalization; the appearance of these symptoms and signs after a digitalis induced diuresis would point to overdigitalization. When uncertain clinically, the distinction between underdigitalization and overdigitalization can generally be made electrocardiographically.

The ventricular rate serves as a valuable

criterion of the degree of digitalization in the presence of auricular fibrillation, but not in regular sinus rhythm. The ventricular slowing in patients with auricular fibrillation under digitalis therapy is a manifestation of depression of conductivity through the atrioventricular node, produced in part by vagal stimulation, in part by myocardial action. With 50 to 75 per cent of the full digitalizing dose, the ventricular slowing is chiefly vagal in origin; apical rates may be reduced to the desired range of 65 to 75 per minute with the patient at complete rest, but rise excessively under light exercise to well over 100, as a result of inhibition of vagal tone.[16] If partial digitalization of this degree is maintained after ambulation, exercise will be tolerated poorly and congestive failure will reappear. As the retained digitalis is increased from 75 per cent to a full therapeutic amount, the fraction of the depressed atrioventricular nodal conductivity caused by direct myocardial action rapidly increases to approximately nine-tenths. This generally succeeds not only in maintaining the resting rate within the desired range, but also in keeping the rate under light exercise below 100 per minute, thereby reducing the likelihood of recurrent failure after ambulation.

If the survey reveals underdigitalization, the next problem is to determine whether a change in preparation or merely an increase in dosage is advisable. Underdigitalization may occur with the tincture as a result of measurement by drops instead of by graduated volume, deterioration from prolonged exposure to air, or irregularities in absorption. Difficulties may be encountered with digitalis leaf because of local gastric irritation or incomplete and irregular absorption. When the degree of digitalis effect remains suboptimal or inconstant, despite a fair trial of tincture or leaf, change to a crystalline preparation is advisable.

Digitoxin is preferable in most cases because of its complete absorption from the alimentary tract, its uniform potency and its prolonged action.[15] If digitoxin was the drug in use at the time the patient was regarded as refractory, it will be necessary to re-evaluate dosage. The standard practice of administering a total of 1.2 mg. to a previously undigitalized patient on the first day and then instituting maintenance doses is inadequate for the majority in severe congestive failure.[13] If the previous regimen has left the patient moderately to markedly underdigitalized, digitoxin may be started in a dose of 0.2 mg. every six hours; if slightly to moderately underdigitalized, digitoxin may be started in a dose of 0.1 mg. every six hours. Since these doses are cumulative and will cause intoxication sooner or later, close observation is obligatory. When therapeutic effects (diuresis, relief of dyspnea) have been obtained, a trial dose of 0.2 mg. digitoxin daily should be substituted for maintenance. This dose is excessive for many patients and may require downward revision. If toxic manifestations supervene, the drug should be withheld until the excess is eliminated and then reinstituted in maintenance doses.

The margin between therapeutic and toxic doses of digitoxin is so narrow in some cases that it is difficult to maintain satisfactory control. Under these circumstances, better control may be obtained with digitoxin, which has a wider margin of safety.[3] If the patient is digitalized at the time of the substitution, maintenance doses of 0.5 mg. daily may be tried; if underdigitalized, doses of 1.0 to 2.0 mg. daily may be necessary temporarily.

Has the Optimal Use Been Made of Diuretics?

Before cardiac decompensation is considered refractory to treatment, the patient will have received a trial of mercurial diuretics. During the 24-hour period after the administration of a mercurial to a patient in congestive failure, a rise in urinary output above 2.5 liters and a reduction in body weight by at least two pounds may be expected. In the event of an unsatisfactory response to mercurials, the following causes must be considered: (1) an undependable route of administration or an inadequate dose; (2) electrolyte depletion with consequent renal refractoriness, resulting from excessive dosage of mercurials, or from repeated vomiting or diarrhea; (3) inability of the kidneys to respond because of a markedly reduced glomerular filtration rate.

Route of Administration and Dosage.—When no contraindication to the use of mercurials exists, the patient in severe congestive failure must receive them by a method that insures absorption of an adequate dose. The oral and rectal routes, though often satisfactory in mild congestive failure or in maintenance therapy, are undependable in severe congestive failure, due to poor or irregular absorption. Practically all patients who are capable of responding to mercurials will obtain satisfactory diuresis from intramuscular injections, provided

that an effective preparation is given in adequate dosage into a non-edematous area. The intravenous route, although slightly more effective than the intramuscular,[2] is seldom necessary and should be avoided because of the rare but fatal shock reaction that may occur from sudden introduction of a therapeutic dose into the circulation.[4] Mercuhydrin, thiomerin and mercupurin are approximately equal in therapeutic effect, but the two former are tolerated slightly better than the latter. The choice of the diuretic is not so important in determining the response obtained as the intelligent use of the agent selected. The usual initial dose of 1 ml. intramuscularly should produce a satisfactory diuresis. The response to this and all subsequent doses should be quantitated by measurements of 24-hour urinary volume and, whenever possible, by daily determinations of body weight. When the results from a 1 ml. dose are unsatisfactory, an intramuscular injection of 2 ml. should be given 24 to 48 hours later. If this is likewise ineffective, an evaluation of the renal status and blood electrolytes is advisable rather than repetition of the injection, further increase in dosage, or change in preparation. On the other hand, if either the 1 ml. or 2 ml. dose proves effective, it should be repeated at intervals of two or three days until clinical signs of peripheral and pulmonary edema have disappeared. Discontinuance before this objective is attained will be necessary if toxic symptoms supervene or if a previously effective dose no longer evokes a satisfactory diuresis. In the latter event, a determination of blood electrolytes and renal functional status is indicated before further diuretic agents are administered.

Electrolyte Depletion with Consequent Renal Refractoriness.—The pharmacologic action of mercurials consists in a depression in renal tubular reabsorption of chloride,[7,20] sodium[38] and potassium,[33] with a resultant loss of these ions into the urine and a consequent increase in urinary volume. The mercurials generally cause a disproportionately greater loss of chloride than of sodium and water.[35] As a consequence, the plasma chloride concentration falls progressively and is replaced by bicarbonate, whereas the plasma sodium remains at a plateau or falls in a slower rate, resulting in a hypochloremic alkalosis. A similar state may be reached in untreated congestive failure as a result of refusal of food, coupled with repeated vomiting. When the plasma chloride concentration falls below 85 m. eq. per liter, the stimulus to conserve the dwindling body stores may overcome the effects of therapeutic doses of the mercurials and may lead to tubular reabsorption of practically all of the chloride in the glomerular filtrate, and secondary inhibition of diuresis. Hypochloremic alkalosis should be suspected as a cause of an inadequate response to the initial dose of a mercurial, if incessant vomiting had been present, and should be suspected as a cause of the development of refractoriness after a series of injections, particularly when an adequate diuresis was obtained after first doses, followed by diminution and then by absence of response. After confirmation of the diagnosis by demonstration of significant lowering in plasma chlorides and reciprocal elevation of blood carbon dioxide combining power, hypochloremic alkalosis may be corrected by the administration of ammonium chloride. Plain tablets or capsules are preferable to the enteric coated preparations, because of the fact that the latter may pass through the bowel unabsorbed. Doses of 2.0 to 4.0 grams of ammonium chloride three times daily are usually tolerated when given with meals and should raise the plasma chloride concentration sufficiently within two to three days to permit a satisfactory response to a mercurial diuretic. The remaining edema can generally be evacuated by a mercurial injection every three days, preceded by ammonium chloride for one or two days.

Hyponatremic acidosis may complicate the combination of ammonium chloride and mercurial diuretics,[36] particularly in the presence of renal disease, and may be responsible for refractoriness to therapy, for muscular cramps, for untoward cerebral symptoms, such as disorientation, stupor and coma, and for circulatory collapse. After confirmation of the diagnosis by the demonstration of a reduction of plasma sodium below 125 m. eq. per liter and of blood carbon dioxide combining power below 30 volumes per cent, the abnormal electrolyte pattern must be corrected by the administration of sodium chloride or sodium bicarbonate. The paradox of sodium administration may restore sensitivity to mercurials and permit a diuresis in patients refractory because of hyponatremia.

Depletion of tissue potassium and hypokalemia

may complicate mercurial diuresis unless the diet contains adequate amounts of potassium to replace urinary losses. Hypokalemia should be suspected at the appearance of apathy, drowsiness, muscular weakness and hypotonia, or dyspnea with gasping respiration or circulatory collapse in a patient who has been receiving mercurial diuretics, but eating little or no food. The diagnosis may be confirmed by demonstration of a low plasma potassium, by typical electrocardiographic findings or therapeutic response to potassium chloride in doses of 2 to 3 grams four times daily.

Inability of the kidneys to respond to mercurials may be encountered when the glomerular filtration rate is reduced well below 50 per cent of normal. Under these circumstances most of the scanty glomerular filtrate may be reabsorbed by simple diffusion through the tubules, even in the presence of therapeutic doses of a mercurial diuretic.[34] This situation should be suspected in patients who fail to respond satisfactorily to the initial mercurial injection, yet show no significant reduction in the plasma concentration of chloride and sodium. The next step is to reinvestigate for evidence of complicating glomerulonephritis, which is a contraindication to the use of mercurial diuretics. If glomerulonephritis, polyarteritis nodosa, "malignant" hypertension and other diffuse lesions of the renal vascular tree or glomeruli are excluded, the markedly reduced glomerular filtration rate may be merely the result of the severe degree of congestive failure. Under these circumstances, complete rest is obligatory to obviate the diversion of renal blood flow produced by exercise. Full digitalization may increase cardiac output and renal blood flow sufficiently to restore responsiveness to mercurials. The xanthine diuretics, which also act chiefly by depression of tubular reabsorption of sodium chloride and water,[17] may significantly enhance the effect of a mercurial and deserve a trial as a preparatory agent in patients who have shown suboptimal responses to mercurials. The most effective of the available preparations are theophyllin and aminophyllin, given in doses of 0.2 to 0.3 grams three times daily with meals. A new agent chemically related to the xanthines, namely, 1 ethyl-3 n propyl-4 amino-uracil, given orally in a dose of 0.3 grams four times a day, appears on preliminary trial to produce a diuresis of water, sodium and chloride comparable to that from a mercurial injection.[24] If further experience confirms the results of the preliminary trial, this agent will constitute a significant addition to the therapeutic armamentarium.

Have Serous Effusions Preventing Restoration of Function Been Aspirated?

Pleural effusions may greatly aggravate dyspnea and are generally absorbed slowly, if at all, under the influence of digitalis and diuretics. During physical examination, special attention should be directed toward the detection of pleural fluid and, if doubt exists, a roentgenogram should be obtained. Significant amounts of pleural fluid should be removed by thoracentesis. Ascites, sufficient to make the abdomen tense, interferes with renal venous drainage and should be removed by paracentesis. In the event of intractable peripheral edema, the Southey-Leech tubes may be employed.

Bibliography

1. Bailey, C. P., Glover, R. P., and O'Neill, T. J.: Am. Heart Assn., June, 1949.
2. Batterman, R. C.: Med. Clin. North America, 34:629, 1950.
3. Batterman, R. C., and De Graff, A. C.: Am. Heart J., 34:663, 1947.
4. Ben-Asher, S.: Ann. Int. Med., 25:711, 1946.
5. Blalock, A., and Kieffer, R. F., Jr.: Ann. Surg., 132:496, 1950.
6. Blumgart, H. L., Freedberg, A. S., Kailand, G., and Urder, A. L.: Tr. A. Am. Physicians, LXII:162, 1949.
7. Blumgart, H. L., Gilligan, D. R., Levy, R. C., Brown, M. G., and Volk, M. C.: Arch. Int. Med., 54:40, 1934.
8. Brock, R. C.: Brit. M. J., 1:1121, 1948.
9. Burch, G. P., Reaser, P., and Cronvich, J.: J. Lab. & Clin. Med., 32:1169, 1947.
10. Burwell, C. S., and Blalock, A.: J.A.M.A., 110:265, 1938.
11. Carter, M. G., Gaensler, E. A., and Kyllonen, A.: New England M. J., 243:549, 1950.
12. Crafoord, C., and Nylin, G.: J. Thorac. Surg., 14:347, 1945.
13. De Graff, A. C., Batterman, R., and Rose, O. A.: J.A.M.A., 138:475, 1948.
14. Garland, L. H., and McKenney, A. C.: Radiology, 38:426, 1942.
15. Gold, H., Cattell, M., Modell, W., Kwit, N. T., Kraver, M. L., and Zahn, W.: J. Pharmacol. & Exper. Therap., 32:187, 1944.
16. Gold, H., Kwit, N. T., Otto, H., and Fox, T.: J. Pharmacol. & Exper. Therap., 67:224-238, 1939.
17. Green, D. M., and Bridges, W. C.: Fed. Proc., 8:296, 1949.
18. Gross, R. E.: Ann. Surg., 124:532, 1946.
19. Gross, R. E.: J.A.M.A., 139:285, 1949.
20. Herman, G., Stone, C. T., Schwab, B. H., and Bondurant, W. W.: J.A.M.A., 99:1647, 1932.
21. Hickam, J. B., and Cargill, W. H.: J. Clin. Investigation, 27:10, 1948.
22. Hines, E. A., Jr., and Waugh, J. M.: Proc. Staff Meet. Mayo Clin., 11:545, 1936.
23. Iseri, L. T., Boyle, A. J., and Myers, G. B.: Am. Heart J., (Nov.) 1950.
24. Kattus, A. A., and Newman, E. V.: J. Clin. Investigation, 29:827, 1950.
25. Kraus, Henry: J. Clin. Investigation, 29:829, 1950.
26. Levine, S. A.: J.A.M.A., 126:80, 1944.
27. Levine, S. A., and Sturgis, E. C.: Boston Med. & Surg., 190: 233, 1924.
28. McMichael, J., and Sharpey-Schafer, E. P.: Brit. Heart J., 6:33, 1944.
29. Merrill, A. J.: J. Clin. Investigation, 25:389, 1946.
30. Merrill, A. J.: J. Clin. Investigation, 25:389, 1946.
31. Merrill, A. J.: Amer. J. Med., 6:357, 1949.
32. Mokotoff, R., Ross, G., and Leiter, L.: J. Clin. Investigation, 27:1, 1948.
33. Mudge, G. H., Foulks, J. G., Ames, A., III, and Gilman, A.: Fed. Proc., 8:115, 1949.
34. Pitts, R. F., and Duggan, J. J.: J. Clin. Investigation, 29:372, 1950.
35. Schwartz, W. B., and Wallace, W. M.: J. Clin. Investigation, 29:844, 1950.
36. Soloff, L. A., and Zatuchni, J.: J.A.M.A., 139:1136, 1949.
37. Stewart, H. J., Deitrick, J. E., et al: Arch. Int. Med., 62:569, 1938.
38. Threefoot, S., Gibbons, T., and Burch, G.: Proc. Soc. Exper. Biol. & Med., 66:369, 1947.

Systolic Murmurs

By Paul S. Barker, M.D.
Ann Arbor, Michigan

SYSTOLIC MURMURS are common. They have been studied intensively for more than a century and still many of them cannot be interpreted with assurance. Because they were often present in persons dying of heart disease, it was generally taught in the last century that systolic murmurs were a sign of serious disease of the heart. About the beginning of the present century it became apparent that systolic murmurs were common in subjects who had no symptoms and no other signs of cardiac disease and that autopsies, when such persons died, disclosed no abnormality of the heart. This led to the view that systolic murmurs alone, in the absence of other evidence of cardiac abnormality, should never be regarded as indicating disease of the heart.[6,7] It was soon recognized that some systolic murmurs are "functional" in origin, while others are "physiologic" or "accidental."[3] More recently attempts have been made to distinguish by the quality or intensity of the murmurs those due to organic disease from those unaccompanied by cardiac abnormalities.[2,5]

A widely accepted classification of systolic murmurs is as follows:

1. *Organic.* These are pathological and are caused by organic disease of the cardiac valves or great vessels or by congenital abnormalities.
2. *Functional.* These are pathological and are due to dilatation of the heart or great vessels, or to conditions which increase the speed of the blood flow, such as anemia, fever and thyrotoxicosis. The valves are normal.
3. *Physiologic.* These are not pathological. They have not been adequately explained, but are not due to disease of the heart.

Many of the organic and functional systolic murmurs can be interpreted correctly because of the accompanying symptoms and signs of the conditions responsible for them. There remain the many instances of systolic murmurs not accompanied by symptoms or signs of disease which might cause them. They include:

1. *Cardiorespiratory murmurs.* These are physiologic. They are often heard only during inspiration and disappear when the breath is held at the end of expiration.
2. *Inconstant murmurs.* Nearly always, these are physiologic.
3. *Constant murmurs.* These are the most perplexing. Most of them are physiologic, but some are pathological as shown by long term follow-up studies. They call for careful and thorough examination.

Systolic murmurs may be graded according to their intensity.[2,5] The louder murmurs commonly prove in the end to be associated with organic cardiac disease; it appears, therefore, that they should be interpreted as organic even in the absence of symptoms or other signs of heart disease. The fainter murmurs usually do not prove to have an organic basis and, in the absence of other evidence of cardiac abnormality, should be regarded as physiologic. The murmurs of intermediate intensity give the most difficulty; in the absence of other evidence of organic disease they should be regarded as physiologic.

Follow-up studies averaging 8 to 9.6 years in rheumatic children with distinct systolic murmurs, but without other evidence of cardiac damage, showed that 42 to 48 per cent developed definite rheumatic valvular disease.[2,4] These observations led to the conclusion that in such cases the diagnosis of organic valvular disease should be made, a conclusion which overlooks the 52 to 58 per cent who did not develop clear-cut organic disease in the follow-up period.[6]

Surely, in the absence of other evidence of cardiac disease, systolic murmurs alone, excepting the very loud ones, cannot signify lesions of sufficient clinical importance to require restrictions or treatment. Beyond the sensible precaution of giving antibiotic prophylactically in the event of surgical procedures, it is best to consider these murmurs as physiologic and therefore harmless. If eventually evidence of organic cardiac disease should develop, that would be time enough to impose restrictions or advise treatment; until then a diagnosis of heart disease should not be made.[8] An unwarranted diagnosis of heart disease often leads to unnecessary restrictions and anxiety, or to so-called iatrogenic heart disease.[1] To diagnose heart disease when it is not present is to make just as serious an error as to fail to diagnose it when it is present.

(References on Page 1501)

From the Department of Internal Medicine, University of Michigan Medical School.

Cardiac Housewife Program of the Michigan Heart Association

By John G. Bielawski, M.D.
Executive Director, Section on Occupational Cardiology
Detroit, Michigan

ONE OF the very important factors in the treatment of ambulatory cardiac patients is teaching them to limit their activities as indicated by their functional status. Modification of the physical demands at work is usually possible in the employed cardiac by means of the industrial principle of selective job placement. Such a change of job is not possible when it is the housewife who is disabled by heart disease. She must continue to be a homemaker, but it is possible to modify the way in which she performs her daily tasks. The physical effort expended at these tasks can be greatly decreased by the application of work simplification methods. This is the technique of the industrial "efficiency expert." Practical courses teaching these work-saving methods are now offered as a community service by the Michigan Heart Association without cost to the cardiac housewife. Applications are accepted only upon approval by the patient's physician.

The idea of applying the industrial technique of work simplification to homemaking activities is not a new one, but its application to the disabled homemaker is quite recent. In 1948 a subcommittee of the New York Association, headed by Dr. Lillian Gilbreth, studied this problem. This resulted in the publication of the booklet, "Heart of the Home," now available from the Michigan Heart Association. In brief, this booklet suggests easier ways of doing housework. The booklet has been widely distributed, but it became clear that a more personal form of teaching was needed, and that it must be shown that work savings in homemaking could be effected without extensive alterations of the kitchen and without the purchase of expensive labor-saving machines. An expert in housework simplification methods was located and interested in this problem. She is Mrs. Frances Sanderson, chairman of the Department of Home Economics of Wayne University, who had been teaching these methods to the "normal" homemaker. In February, 1950, she was given a cardiac homemaker to study under medical guidance. Analysis was made of the daily work habits of the patient, recording each detail performed. Waste motions and useless trips were pointed out; rearrangement of dishes and utensils were made; a cart to transport dishes and utensils was suggested. In the preparation of one meal alone, these simple changes resulted in cutting steps walked from 672 to 266, stooping from twenty to eight times, standing on tiptoe from forty-four to twenty-nine times. The total number of steps alone saved at preparing this one meal were calculated to represent a savings of sixty-one miles in a year. The patient become very motion conscious and was soon finding new short cuts by herself. She found that not only was her actual workload decreased but that she had more time in which to rest, for the more efficient method was also shorter. She told us that she was now able to plan her rest periods rather than interrupt a job because dyspnea made her rest. She also was very happy because she said that she was now able to do more for herself yet feel no fatigue at the end of the day. It was felt that this was proof that work simplification was of value to a cardiac homemaker. Therefore, other cases were studied and the same interest generated in the patients. Our home economist consultant meanwhile was learning of the restrictions important to the cardiac. Pictures were taken, charts and graphs drawn of the changes in arrangement. Thus, visual teaching aids were obtained during the study of actual cardiac patients. It is these data which are now being offered in the course for the cardiac housewife at Wayne University. The changes suggested are inexpensive and can be done even by the husband who is not a "handy man." A similar type of class is now being organized for presentation throughout the state in co-operation with Michigan State College.

The present class for cardiac housewives is housed in the Home Economics Department of Wayne University. It is located on the ground floor. The room used contains model kitchens of various types. Thus individual problems can be discussed and particular advantages of different kitchen layouts can be demonstrated. The classes are limited to sixteen per session in order that they can be divided into groups of four for individual conferences between lectures and demonstrations. Two class sessions constitute a course. They are

(Continued on Page 1447)

Medicine and the Public

By L. Fernald Foster, Ph.B., M.D.
Bay City, Michigan

BEING a practicing doctor of medicine, I am speaking tonight as a representative of more than 5,000 practicing doctors of medicine in Michigan. I am their official spokesman on this occasion, and I intend to give you the opinions and thoughts of the medical profession of Michigan in regard to matters having to do with the general elections on November 7. I have emphasized that I am their official representative, and that I have been instructed to bring you this message because no man can then truthfully say that the information, opinions, accusations and facts which I present here are simply those of one man or of a small group of men. What I am saying tonight are the thoughts of your own doctor.

I intend, first, to tell you why this time on the air has been purchased for my talk. Second, I shall point to several untruths which are misleading the American people, and third I shall present some facts which you, as an American citizen, should know.

These will be offered in the belief that truth is stronger than falsehood. Doctors of medicine base their art and their science on truth; if it were not so, many of you who are alive today would long since have passed away.

Fortunately for scientific medicine and perhaps unfortunately for your future health, doctors of medicine are not propagandists. They do not know the art of the "Big Lie," which I am told, if repeated often enough, becomes accepted as truth. They do not practice the art of spreading malicious rumor, for they are trained, as you want them to be, in keeping inviolate your confidence and your trust. Doctors of medicine are not, generally, great writers or speakers. They could not from the rigorous demands of medical education conscientiously devote sufficient time to become masters of the spoken and written word and engage in malicious propaganda techniques. This the doctors of medicine do know: they know how to keep you healthy; they know how to care for you when you are sick; they recognize and are intensely aware of those factors, both economic and social, that can and do affect your health and well being.

That is why doctors of medicine devote the greatest share of their time to the maintenance of the one thing in which they are most interested —your health.

Because these things are so, the medical profession of Michigan—and throughout the United States—is fighting mad today and is assuming a militant attitude against the purveyors of malicious lies. The profession has no quarrel with you, Mr. Taxpayer. It is angered because your tax money is being used freely by the propagandists to spread brutal falsehoods which hurt you and your chances for continued good health. These same tax-supported falsehoods will eventually stunt the efficiency of our medical profession, the greatest in the world, a medical profession that has, under free enterprise, increased man's life span more than twenty years in the first half of the 20th Century.

Here is the first falsehood of the propagandists —they state that the medical profession is a closed corporation which is restricting the number of doctors being trained in order that there will be more demand for the services of the doctors now in practice. This frank mistatement has been voiced again and again by persons now on the payroll of the Federal government.

Here is the truth. For years the medical profession of Michigan has consistently urged the Michigan Legislature that funds and facilities be made available so that the University of Michigan Medical School and Wayne University College of Medicine might accommodate and train additional doctors of medicine. As late as last September 19, it repeated its plea by adopting a resolution asking for "the development of an aggressive and early campaign to secure from the State of Michigan, and from alumni and other citizens who are interested in better health, funds necessary to enlarge medical facilities and faculties in the state to the end that the resulting increase in the number of medical graduates from the University of Michigan and Wayne University is sufficient to continue to give adequate and good quality medical care to the people of this state."

And so, ladies and gentlemen, I repeat that it is a deliberate falsehood to say that the medical profession does not want more doctors of

Radio Address by L. Fernald Foster, Ph.B., M.D., Secretary, Michigan State Medical Society, November 1, 1950, 10:00-10:15 p.m., Radio Station WJR, Detroit, Michigan.

medicine to be trained. A correlated lie is that doctors' sons are given preference in gaining admission to medical schools. While many such sons do become doctors, the reason for this is quite obvious. Most sons tend to follow in the father's footsteps, particularly when they greatly admire their fathers. The same thing holds true of lawyers' sons who become lawyers, and coal miners' sons who become coal miners through association with their fathers. Doctors' sons absorb the challenge of medicine and its art through their environment and determine early in life to become part of the medical profession. As a direct result they are inherently better qualified at the time for entrance into medical school. But so far as preference for doctors' sons is concerned, I can cite instance after instance where pressure and persuasion by a doctor for his own son has been of no avail; therefore it is obviously untrue that medical schools are more easily entered by doctors' sons.

And here is another deliberate major falsehood:

It is often heard that you can't get a doctor when you need one. Here is the truth. A great statewide survey of Michigan was recently completed by Michigan State College in the most unbiased fashion. Here is what the survey found: Less than 2.5 per cent of the people of Michigan reported *ever* having been unable to get medical care when they needed it. Of this 2.5 per cent less than *3/10 of 1 per cent* of the people report ever having bad results because they couldn't get a doctor—a record second to none in any profession or business anytime, anywhere.

With this factual information, I repeat: The lie of "You can't get a doctor when you need one" can be definitely repudiated.

The international crisis in Korea provided the basis for another unfounded and untrue statement. It was said that the medical profession failed to supply doctors to the armed services in the sudden demand created by the Korean conflict. Let us look at the record: The recent Federal legislation to draft doctors was supported by the American Medical Association, the Michigan State Medical Society and the medical profession generally, because bungling preceded this draft through taking doctors from areas where they were badly needed, simply because the doctor in that area was a reservist. Let me cite but one typical example: that of Mesick, Michigan. The citizens of that representative American community worked hard to make it possible for a doctor to locate and practice there. They built a building by voluntary labor. The building was equipped by the Kellogg Foundation and a well-trained young doctor was obtained. He had scarcely begun practice when he was called by the government to active service. Now this community of 1,800 persons, like before, is again without a doctor of medicine. The medical profession sincerely felt a doctor draft law would permit the orderly and organized selection of doctors from those areas where there is an abundance of doctors. That *is being done today* through committees of the medical profession itself under the new draft law.

It isn't hard to recall that more than 1,500 Michigan doctors of medicine saw service in World War II—and every one of them on a voluntary basis.

How can it be fairly stated that the doctors ever failed to willingly supply their country with patriotic service in time of need? Yet that statement has been made and is being repeated by persons paid with your tax dollars.

Another of those "Big Lies" which have been repeated over radio stations in Detroit and in every major city in the United States is the one first told by an employe of the Federal government and relayed to the people over and over again by his press agents who were paid by your tax dollars.

It is that the American Medical Association spent $20,000,000 on an advertising campaign of lies to the American people.

First let me ask a question. Have you seen this advertisement? It seems as if you should have if twenty million dollars had been spent to bring this ad to your attention. For that amount of money it would seem that a great many advertisements might have been placed before your eyes. And if you have seen it, what were the lies in it?

The real truth is that only one advertisement was placed by the American Medical Association. The advertisement ran only once in the newspapers and periodicals of this nation. A few radio spot announcements were made over some of the nation's radio stations. What was the theme of the message—simply that the voluntary way is the American way . . . well . . . isn't the voluntary way the American way?

How much money was spent by the American

Medical Association? The amount was less than one and a quarter million—not twenty million. And whose money was used? Not the money you pay in taxes. No, it was a small contribution by your family doctor and the other family doctors of the country. The sum of one million seems great to you and me. It shrivels into insignificance when compared with the $75,000,000 of your tax money which I understand was admittedly spent by Mr. Oscar Ewing, Federal Security Administrator, et al. for increased social security and to convert you to the belief that compulsory health insurance is a necessity. That the American Medical Association spent $20,000,000 is another typical example of false propaganda being hurled against your medical profession.

What is the medical profession doing to combat this organized flood of misrepresentation to the American public?

As an organization it is doing its best to tell the truth and to get out the vote. It is willing to abide by the will of the people expressed in the voting booths of this nation on November 7.

As an organization we of the medical profession are pointing out the dangers of Socialism of which socialized medicine is merely an integral part. Today this philosophy threatens you and me and this entire nation with the loss of the basic liberties that have made this country the finest place in the world to live in.

Socialism is based on compulsion, confusion and piecemeal engulfment, eventually leading into a Communistic state. Socialism might be likened to infantile paralysis. It is often insidious in its onset and can be readily confused with other less devastating conditions. Socialistic programs are often disguised by a "false face" of altruism and benevolence.

No nation would knowingly accept Socialism or Communism if they understood what it meant, and therefore it has to be introduced insidiously and through the emotions. The greatest emotional appeals made by the proponents of Socialism and Communism are those concerned with aspects of health. Throughout the world wherever the doctrine of Socialism has been introduced it has been the medical services that have been first attacked and Socialized. A perfect example of this is England where the medical profession first—and a few weeks ago the legal profession—fell under the Socialistic yoke. Today England is not jolly but rather labors under a full-fledged austerity program with ample distribution of poverty and want. Another beautiful example of this is a recent advertisement over the signature of the CIO National Health Committee—whatever that is—wishes to place the whole program on a compulsory basis run by Washington bureaucrats instead of the *voluntary* basis. And remember that it is the voluntary way that is today keeping the United States the healthiest large nation in the world and doing so without endangering our liberties or freedoms of choice.

What else is the medical profession doing to combat the trend toward Socialism?

Individual members of the medical profession are doing their best to eliminate from political advantage those persons who by their deeds, their attitudes and their company, indicate they are in favor of Socialism. Individual doctors are doing their best to support those candidates who believe that the voluntary way is the American way.

What further is the medical profession doing? It is seeing to it that *no one* lacks medical care. It is working in the great voluntary health organizations of Michigan to control disease. The medical profession is responsible for the organization of and the success of the greatest voluntary health insurance movement in the world today. In Michigan alone this system protects over four million persons and is growing every day. I speak of Blue Cross-Blue Shield and the many other health insurance programs available in Michigan today.

How many of you have some form of voluntary health insurance? How many of your friends? Millions of you—and yet the voluntary health insurance movement is less than fifteen years old in Michigan. In addition, over one million other persons in Michigan are in categories qualifying them for free medical care.

How is the medical profession organized, how does it co-operate with others in building a healthier America? The medical profession is organized on a county, state and national basis. It is absolutely voluntary. No doctor is forced to become a member of organized medicine. It is not necessary to be a member to practice medicine. That's quite a bit different from a closed shop, isn't it? The medical profession has and is constantly cooperating with every agency genuinely interested in the health of the people. It has worked with the Michigan Health Council and the Michigan Rural Health Conference, the Michigan Heart As-

sociation, the Michigan Foundation for Medical and Health Education, the Michigan Industrial Health Conference, the State Department of Health and many others, and in fact was responsible for the organization of these groups mentioned. There is no major health organization in Michigan, with the possible exception of the CIO National Health Committee—and I'm still wondering what that is—with which the medical profession both as individuals and as an organization has not worked harmoniously.

The medical profession in Michigan is determined that *no one who asks for it shall go without medical care in this state.*

My time is about up, but I should like to leave you with several thoughts:

Choose carefully on November 7. Then make your choice on your ballot. Let it be your choice—not that of any other persons or group.

However, a word of caution: think carefully before voting for any party or any candidate which is dedicated to any segment of the Socialistic pattern. Time and bitter experience have proven only too realistically that Socialism with socialized medicine as a starter leads to four avenues of "no return": (1) inferior quality of medical care, (2) additional staggering tax burdens, (3) abrogation of the personal liberties of free choice, and (4) a toehold for complete national socialization.

In closing, may I restate that which great American Benjamin Franklin said many years ago—and which holds so true today—"A people which would exchange its liberty for a fancied and transient security deserve neither liberty nor security."

Thank you so much—and let's meet with all good citizens at the polls next Tuesday, November 7.

MSMS

WHAT THEY SAY

"The September JOURNAL was the best I have ever seen."—G. K. SWARTZ.

"I appreciated the last issue of THE JOURNAL very much, and think that it did an excellent job of bringing our information on ACTH and cortisone up to date."—W. H. HURON.

"I wish to congratulate you on the excellence of the editorials in the October JOURNAL."—R. L. NOVY.

"The September JOURNAL on rheumatism and cortisone was a great contribution, and was a course of instruction unsurpassed."—J. J. JEFFREY.

New Influenza Virus Discovered

A new virus strain, which may prove to be another type of influenza, has been found in an epidemic of acute respiratory disease by the Armed Forces Epidemiological Board, according to an article appearing in the current issue of *Science.*

The new strain was discovered during an investigation conducted earlier this year in Michigan by the Board's Commission on Influenza, which operates under the auspices of the Army Surgeon General.

The Armed Forces Epidemiological Board furnishes advice to the Armed Forces in establishing uniform and effective epidemic prevention and control procedures. Established in 1941 as the Army Epidemiology Board, its function was expanded last year to study medical, operational, and research problems of the three services.

The Commission, one of nine now operating under the Board, has been searching for causes related to some of the other acute respiratory epidemics.

Dr. Thomas Francis, Jr., director of the Commission, Dr. J. J. Quilligan, Jr., and Dr. Elva Minuse co-operated in the studies. All are members of the Department of Epidemiology, School of Public Health, University of Michigan.

Studies up to the present have disclosed two clear-cut categories of influenza, A and B, as well as some rather pronounced differences between sub strains belonging to each of the types.

The new virus—which could be called Influenza C—was isolated during a mild outbreak of influenza associated with A-prime strains of virus which occurred in Ann Arbor last spring.

Efforts to relate the virus to other known respiratory diseases were unsuccessful. Studies with animal serums failed to show a relation to known influenza virus, to Newcastle disease virus, to mumps virus, the Texas, Ohio and Connecticut strains of Coxsackie virus, or to the pox groups of virus. All tests showed negative results to these common infectious diseases, indicating that the newly discovered virus seems to be serologically and immunologically distinct from previously identified strains of influenza virus.

Of particular interest was the testing of serums

(Continued on Page 1495)

From U. S. A. Surgeon General's office.

Saline Solution in Treatment of Burn Shock

THE Surgery Study Section of the National Institutes of Health has recommended to the Surgeon General of the Public Health Service that the use of oral saline solutions be adopted as standard procedure in the treatment of shock due to burns and other injuries in the event of large-scale civilian catastrophe.

The recommendation followed action taken at the January, 1950, meeting of the Surgery Study Section, when such treatment was approved in principle. Dr. Carl A. Moyer, a member of the Study Section, was designated at that time to prepare a memorandum suitable for submission to Dr. Norvin A. Kiefer, Director, Health Resources Division (now Health Resources Office), National Security Resources Board.

Dr. Moyer's memorandum, which was submitted to Dr. Kiefer, February 15, 1950, reads as follows:

"Since the publication of the experimental work of Dr. Rosenthal, Dr. Coller, et al, orally administered salt solutions have been employed in the treatment of burns at the University of Michigan Hospital, Ann Arbor, Michigan, at the Wayne County General Hospital, Eloise, Michigan, and at Parkland Hospital, Dallas, Texas. Personal clinical experience, in the above-named hospitals, has convinced me that the orally administered salt solutions are valuable adjunctive agents in the treatment of shock incident to burns, fractures, peritonitis, and acute anaphylactoid reactions. Certain factors are important in governing the effectiveness of the oral administration of salt solutions. They are as follows:

"1. The composition of the salt solution: The most palatable salt solution is made by dissolving 3 to 4 grams of sodium chloride and 2 to 3 grams of sodium citrate in each liter of water. If sodium citrate is not available, ordinary baking soda may be substituted for it.

"2. The concentration of salt should not be in excess of 140 milliequivalents of sodium per liter. If the concentration is above this, vomiting and diarrhea became important complicating factors.

"3. Whenever profound peripheral circulatory collapse is present, the intravenous route of administration must be used until peripheral blood flow has been reestablished. The salt solutions that we have found most satisfactory for this purpose are Hartmann's solution (Lactate-Ringer's solution) or plasma. In addition to the salt solution or plasma intravenously, whole blood is given concurrently whenever peripheral circulatory collapse exists. This materially implements the effectiveness of salt solutions.

"The slightly hypotonic salt solution is the only drinking fluid permitted the injured individual until the edema of the injured parts begins to subside. Certain exceptions to this rule have to be made during the hot weather of summer when it is sometimes necessary to permit the partaking of some non-salty water.

"As much as 10 liters of the hypotonic salt solution have been drunk in the twenty-four-hour period by adults who have been severely burned. Since salt solution has been substituted for water, as a drinkable fluid, no burned person who has lived for longer than three hours after being admitted to the hospital has suffered from anuria. The 'early toxemia phase' of the burns has also failed to appear, and the osmotic concentration of the plasma electrolytes has been well maintained.

"We feel that much more clinical observation and actual experimental work should be undertaken regarding the effectiveness of the basic principles of the supportive therapy of burns that have been so beautifully demonstrated by Dr. Rosenthal. It is obvious that the adoption of a more active program of investigation into the relative effectiveness of simple measures to combat shock would be of extreme importance to the Armed Forces and to the civilian population in the event of another war"

Because of the sharpened national emergency that developed during the summer of 1950, the Surgery Study Section, in approving Dr. Moyer's memorandum at its meeting on September 16, changed the last paragraph to read:

"While further clinical research concerning the effectiveness of oral salt solution in the treatment of burns and other injuries is certainly in order, there is already sufficient evidence to suggest that this form of treatment should be used in any large-scale disaster involving the civilian population."

The Surgery Study Section letter to the Surgeon General, dated September 16, 1950, reads as follows:

"It is my understanding that one of the functions of the Study Sections is to offer advice to the Surgeon General in fields of medicine lying within the special competence of the Study Section members. At the January, 1950, meeting of the Surgery Study Section, there was considerable discussion concerning the use of oral saline solutions in the treatment of burns and other serious injuries. It was the consensus of the Section at that time that, on the basis of the animal work which had been done by Dr. Rosenthal of the National Institutes of Health, and the clinical work which had been done by Dr. Carl A. Moyer, by the undersigned, and by others, the efficacy of such treatment had been definitely demon-

---

Submitted by Naval Surgeon General Leonard A. Scheele, for general distribution as especially valuable in case of any large scale disaster:

"I would invite your attention to the very important fact that this recommendation will in no sense decrease the need for whole blood, and must not be construed as lessening in any way the importance of blood bank programs. It is our considered opinion, however, that information on sodium treatment might well be included immediately, as an emergency procedure, in first aid training programs."
—LEONARD A. SCHEELE, *Surgeon General*

strated and that, while there is need to stimulate additional research in this field, our present knowledge is sound enough so that action can be taken on this basis. Dr. Moyer was designated to draft a short memorandum expressing our point of view on this subject. Such a memorandum was prepared and furnished to Dr. Norvin C. Kiefer, Director, Health Resources Division, National Security Resources Board, on February 15, 1950. A copy of Dr. Moyer's memorandum is attached.

"In view of the more acute national emergency that has developed since Dr. Moyer wrote this memorandum, the Study Section, at its meeting on September 16, 1950, voted to recommend that the principles of treatment outlined in his memorandum be adopted for widespread use in any large-scale disaster involving the civilian population. Because of the present emergency situation, we have modified the last paragraph of Dr. Moyer's memorandum to read, 'While further clinical research concerning the effectiveness of oral salt solution in the treatment of burns and other injuries is certainly in order, there is already sufficient evidence to suggest that this form of treatment should be used in any large-scale disaster involving the civilian population.'

"You are at liberty to transmit this recommendation of the Surgery Study Section to the National Security Resources Board or to other proper agencies, and, if you see fit, to publish it. We feel strongly that it is important for the medical profession of the country and for those planning for the handling of potential disasters to be informed of the value of this simple and easily carried out form of treatment."

The letter was signed by Frederick A. Coller, M.D., University of Michigan, chairman of the Surgery Study Section. Members of the Study Section, in addition to Dr. Coller, are: Dr. Claude S. Beck, professor of neurosurgery, Western Reserve University; Dr. Loren R. Chandler, dean, Stanford University Medical School; Dr. Lester R. Dragstedt, professor of surgery, University of Chicago; Dr. Daniel C. Elkin, professor of surgery, Emory University; Dr. Carl A. Moyer, dean and professor of surgery, Southwestern Medical School, University of Texas; Dr. Harris B. Shumacker, Jr., professor of surgery, Indiana University Medical Center; Dr. Owen H. Wangensteen, professor of surgery, University of Minnesota; Dr. Allen O. Whipple, clinical director, Memorial Hospital, New York City; Dr. H. L. Skinner, chief of surgery, Staten Island Marine Hospital; Dr. Henry Beecher, professor of anesthesiology, Harvard University Medical School; Dr. J. Gordon Lee, chief of surgery, Mount Alto Hospital, Washington, D. C.; Dr. Howard R. Lawrence, chief of surgery, Francis E. Warren Air Force Base Hospital, Wyoming; and Dr. G. Halsey Hunt, Chief, Division of Hospitals, Public Health Service.

References*

1. Allen, F. M.: Theory and therapy of shock. Am. J. Surg., 62:80-104, 1943.
2. Fox, C. L., Jr.: Oral sodium lactate in treatment of burns and shock. J.A.M.A., 124:207-212, 1944; Surg. Gynec. & Obst., 80: 561-567, 1945; Am. J. Physiol., 151:155-167, 1947.
3. Harkins, H. N.: Sodium therapy of experimental tourniquet shock. Am. J. Physiol., 145:538-545, 1947.
4. Katz, L. N.; Friedberg, L., and Asher, R.: Efficacy of isotonic sodium chloride and glucose in preventing shock following venous occlusion of a limb in the dog. Am. J. Physiol., 140: 65-71, 1943.
5. McCarthy, M. D., and Parkins, W. M.: Comparative effectiveness of albumin, globin, hemoglobin, gelatin, oxypolygelatin, saline, Ringer's, blood, and plasma upon the survival of rats subjected to standardized scald burns. Am. J. Physiol., 150: 428-443, 1947.
6. Moyer, C. A.; Coller, F. A.; Iob, V.; Vaughn, H. H., and Marty, D. A.: Study of the interrelationship of salt solutions, serum, and defibrinated blood in the treatment of severely scalded, anesthetized dogs. Ann. Surg., 120:367-376, 1944. Moyer, C. A.: Texas State J. Med., 45:635-639, 1949.
7. Reynolds, M.: Cardiovascular effects of large volumes of isotonic saline infused intravenously into dogs following severe hemorrhage. Am. J. Physiol., 158:418-428, 1949.
8. Rosenthal, S. M., and Tabor, H.: Experimental chemotherapy of burns and shock. Pub. Health Rep., 58:513-522; 1429-1436, 1943; 59:637-658, 1944; 60:373-381; 401-419, 1945; Am. J. Physiol., 149:449-464, 1947; Arch. Surg., 51:244-252, 1945.
9. Scott, C. C.; Worth, H. M., and Robbins, E. B.: Comparative value of some blood substitutes used for treatment of experimental shock. Arch. Surg., 48:315-318, 1944.
10. The fluid and nutritional therapy of burns. Report by the Sub-Committee on Shock, Natl. Research Council. J.A.M.A., 128:475-479, 1945.

*This does not represent a complete bibliography.

MSMS

CARDIAC HOUSEWIFE PROGRAM OF THE MICHIGAN HEART ASSOCIATION

(Continued from Page 1441)

held on consecutive Tuesdays and Thursdays in order that a week's interval may elapse in which the class members can make some of the suggested rearrangements. The course is not limited to meal preparation and kitchens, but also includes bedmaking, cleaning, dusting, and other household tasks. Request for an application blank is made by the patient to the Michigan Heart Association by letter or telephone.* The application blank contains a small space for the physician to indicate activities permitted the patient. This is for guidance of the instructors since there is no examination of patients or treatment. Upon completion of the application form, the patient is notified of the time and date of the class. The classes are open to women of all economic levels.

The Cardiac Housewife Program of the Michigan Heart Association is designed to be of aid to the physician in the management of his cardiac housewife patients. It will fill the doctor's prescription of "take it easy" by showing her *how* to take it easy, yet accomplish as much of her own work as possible.

*4421 Woodward Avenue, Detroit 1, Michigan. TEmple 1-6400.

Holiday Review

WE must always bear in mind that not only are the rules governing medical practice numerous, but that each law or ethical regulation is surrounded by emotional hazards.

For purposes then of a brief study, we can outline those duties as imposed by law as follows:

The doctor is not obligated to accept employment. The ability of the patient to pay or not to pay does not alter the situation.

Once the doctor has undertaken treatment he must continue to render such services as the advanced state of his profession, in his or similar localities, requires.

The doctor may refuse to treat a patient in a particular hospital.

The patient and the doctor may by agreement limit the terms and conditions of the implied contract.

The doctor shall be the judge of the necessity and the frequency of his visits. In case of implied neglect, however, the jury will be the judge. Other professional engagements do not excuse the physician for not rendering necessary services.

Gratuitous treatment in no respect qualifies the liability of the physician.

In case of temporary absence the patient must be notified and told who will be in charge of his care during his doctor's absence. If a partner, agent or employe is selected, the original doctor is still liable. If the recommended doctor is an independent practitioner, then the only responsibility is in selecting a competent physician.

Neither a doctor nor his patient need continue a contract longer than is pleasing to them, providing that the party desiring to terminate the relationship gives the other reasonable notice.

The medical profession is most anxious that the above rules shall be complied with. We believe that rendering the best medical care possible, at a fee within the patient's ability to pay, will avoid most legal entanglements. We commend the profession of the State of Michigan for the paucity of cases which have reached our Mediation Committee and our Ethics Committee. Although no plaudits are expected, this is the finest type of public relations any organization can practice.

We have viewed with alarm the marked increase in malpractice suits in certain sections of the country. Various reasons have been given, such as:

Ill-advised admissions concerning the medical care given.

Poor case records.

Inadequate x-rays.

Filing suit by the physician for his fee before the Statute of limitations has run its course.

Responsibility for the acts of others.

Exorbitant fees.

As a weapon of intimidation.

Negligence inasmuch as the doctor fails to keep abreast of recent advancements in medical care.

In addition to knowing the above laws and the hazards surrounding them, the doctor of medicine must know and be guided by the "Principles of Medical Ethics" of the American Medical Association. These deal with the physician's deportment in and outside of the medical profession. It is not to be supposed that these regulations cover the entire field of medical ethics or that the physician is not under many obligations besides those set forth. The Golden Rule of "Do unto others as you would have them do unto you" must be incumbent on each physician in his deportment toward the public and his fellow practitioners.

The laws and ethics, as listed above, are primarily for the good of the public. Their enforcement should be conducted by the medical profession in such a manner as shall deserve and receive generalized endorsement. The cost is little but the reward is great.

As we regard 1950 in retrospect we believe the medical profession of Michigan has acquitted itself with honor. In many of its endeavors the Michigan State Medical Society has gone beyond the requirements of the laws and ethics herein quoted. For that reason the Holidays should bring much happiness and contentment in a job well done.

The officers of the Michigan State Medical Society wish every member a most pleasant Christmas, and in 1951 may we really see a world united in peace.

C E Umphrey M D

President, Michigan State Medical Society

President's Message

ANNUAL COUNTY SECRETARIES—PUBLIC RELATIONS CONFERENCE

January 21, 1951

Book-Cadillac Hotel—Crystal Ballroom

Detroit, Michigan

WM. M. LE FEVRE, M.D.
Chairman of Secretaries

THEME

Organization and Communication—Key to Effective Medical Activity

TENTATIVE PROGRAM

MORNING—9:30 a.m. to 11:45 a.m.

W. M. LE FEVRE, M.D., Michigan, *Chairman*

A. Channels of Communication

1. From AMA and other national organizations to MSMS
   By EDWARD J. MCCORMICK, M.D., Toledo, Ohio, Trustee of American Medical Association.
2. From MSMS to County Medical Societies
   By C. E. UMPHREY, M.D., Detroit, President, Michigan State Medical Society.
3. From County Medical Societies to the people
   By HAROLD J. MEIER, M.D., Coldwater, Michigan.

B. Media of Communication

1. Motion Pictures, Radio and Television
   By JAMES E. LEWIS, East Lansing Production Director, Capitol Film Service.
2. Newspaper
   By JACK PICKERING, Detroit, Science Writer of *Detroit Times*
3. Public Speaking, Conversation, Telephone—Telegraph, and Letters (direct mail)
   By A. WESLEY ROWLAND, Alma, Michigan, Alma College.

NOON DAY DINNER—12:00 noon to 1:45 p.m.

R. J. HUBBELL, M.D., Kalamazoo, *Chairman*

C. Luncheon Speaker

MAJOR GENERAL GEORGE ARMSTRONG, M.C., Deputy Surgeon of the Army, Washington, D. C.—*"The Wartime Role of the M.D.—In and Out of Uniform."*

AFTERNOON 2:00 p.m. to 4:00 p.m.

L. W. HULL, M.D., Detroit, *Chairman*

D. Governmental and Economic Questions

1. Governmental Contacts and the Legislative Outlook for 1951
   By WILLIAM PALMER, Lansing, Exec. Secy., Michigan Petroleum Industries Committee.
2. Taxes and Insurance
   By ROBERT B. L. MURPHY, Madison, Wisconsin, Legal Counsel, State Medical Society of Wisconsin.
3. Medical Service in Labor Relations
   By EARL R. BRAMBLETT, Detroit, Labor Relations Department of General Motors Corporation.
4. Co-ordination of Medical and Health Organization—County and State
   By L. FERNALD FOSTER, M.D., Bay City, Secretary, Michigan State Medical Society.

Editorial

THE MICHIGAN HEART ASSOCIATION

THE MICHIGAN Heart Association is not yet two years old. Its second birthday will be February 17, 1951, the anniversary of its incorporation. Its Articles of Incorporation state that it is formed for the following purpose: ". . . the acquisition, dissemination and application of knowledge concerning the normal heart and circulation and the causes, diagnosis, prevention and treatment of disorders of the circulation and diseases of the heart, blood vessels and lymph vessels. . . ." A critical examination of the achievements of this infant organization reveals an astonishing record of accomplishments for one so young!

For the "acquisition of knowledge" the Michigan Heart Association actively supports both basic and developmental research projects in Michigan's medical schools and hospitals. A complete list of grants for 1950-1951 is listed elsewhere in this issue. It will be found that both the medical and the surgical aspects of heart disease are represented, that research work is being done in a number of different institutions, and that a number of different types of heart disease are under scrutiny. The M.H.A. in addition contributes substantially to research projects on the national level: twenty-five per cent of its income goes to its parent organization, the American Heart Association, one-half of this amount being earmarked for basic research throughout the nation. Qualified Michigan investigators can apply for help from this source as well.

For the "dissemination of knowledge" the Michigan Heart Association has organized a program of educational activities both lay and professional. The current issue of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY largely devoted to heart disease, the Association's Annual Heart Day (March 17, 1951, program elsewhere in this issue), the Speakers Bureau offering topics on heart disease for the scientific meetings of County Medical Societies, the Association's information service and publicity activities for the public—all speak for themselves.

For the "application of knowledge" the Michigan Heart Association supports a limited community service program. Belonging in this phase of its activities are its support of the Michigan State Medical Society's rheumatic fever control program featuring the establishment of Rheumatic Fever Diagnostic and Consultation Centers within the reach of every patient and his family physician in the state, the Cardiac Housewife Program described elsewhere in this issue, the program in Industrial Cardiology.

The Michigan Heart Association was formed by a committee of the Michigan State Medical Society who deserve full credit for initiating the formation of a heart association in Michigan under the auspices of the medical profession. A distinguished group of lay members have contributed immeasurably to its success. In order to be relieved of the burdensome, inefficient and expensive job of raising the necessary funds independently, the Michigan Heart Association has chosen to become a member agency of the United Health and Welfare Fund of Michigan, Inc.

The Michigan Heart Association is a voluntary, privately supported health agency, and fully deserves your interest and your active participation.

—L. D. V.

CHRISTMAS REJOICINGS

THIS IS the month of the Christmas season with its universal felicitations and rejoicings. The Michigan State Medical Society, through The Council and THE JOURNAL, offers all the season's best hopes and joys to our members and their loved ones. May the anticipations of the New Year be the greatest blessings you desire and deserve.

We have reason for elation. The elections have removed from public office some of the ardent proponents of "National Compulsory Health Insurance": Senators Claude Pepper of Florida, Glen Taylor of Idaho, and Frank P. Graham of North Carolina lost in the primaries. The election carried away Representatives Andrew J. Biemiller of Wisconsin, George H. Wilson of Oklahoma, Neil J. Lineton of Illinois, Helen Gahagan Douglas of California, candidate for the Senate; and Senators Elbert D. Thomas of Utah, Francis Mey-

ers of Pennsylvania, and Millard Tydings of Maryland.

The election returned to office by overwhelming odds Senator Robert Taft of Ohio, and also all the friendly Republican members of both the Senate and House committees which handle the health insurance bills, except our very good advocate, Senator Forrest C. Donnell of Missouri.

The defeat of Senator Scott Lucas of Illinois, the majority leader, lends hope of a respite for a period. Senator Lucas belatedly disclaimed favoring "socialized medicine," but he was the administration leader, and medicine may well feel satisfied.

Such in very brief is another justification for the Season's happiest "God bless you."

WE HAVE THE RIGHT

THE AMERICAN Medical Association in October advertised to the public the merits of private enterprise and private practice of medicine. The Association has been soundly criticised by some for its efforts.

Mr. John D. Dingell, Congressman from Michigan, made a speech in Congress strongly critical of the Association's advertising program and of its campaign for defense. He reprinted this speech as coming from the *Congressional Record* with a headline of letters one-half inch high. "HELP FIGHT MEDICAL LOBBY TWENTY MILLION DOLLAR SMEAR CAMPAIGN." The idea very evidently is to discredit the American Medical Association and its motives.

Taxpayers' money was used to print Mr. Dingell's speech and other material in the *Congressional Record,* even though he did append the line "Not printed at Government expense." The *Record* is certainly printed at Government expense; the reprints may be different, but how about the Franking privilege in distribution of Congressmen's mail?

* * *

Mr. Oscar Ewing, Federal Security Administrator, in a speech before the American-Jewish Congress implied that the American Medical Association was practicing discrimination against the Jews. What object could he have but to bring discredit upon the American Medical Association?

Mr. Ewing's department had spent upwards of seventy-five millions of dollars up to 1948 in propaganda for the Federal plan of socialized medicine which they euphoniously call "Compulsory Health Insurance." Recently Mr. Ewing testified at a Congressional hearing that this was not only his privilege but his duty in loyalty to the administration.

* * *

Many newspapers throughout the country in late October carried a quarter page advertisement, slanderous and probably libelous, about the American Medical Association. The ad is in the form of a letter from a mother accusing the profession of opposing or defeating a list of nine programs, expressing false statements or half truths, but designed to place the profession in a wholly false and intolerable light. This was from the "CIO National Health Committee," which has placed itself on the list of "social planners," the Fabians of America.

The medical profession is attempting to maintain itself as a private and non-bureaucratic enterprise. But this is a fight not for ourselves alone. It is to save our nation from an encroaching Socialism, which is now vigorously threatening education, agriculture, banking and insurance.

The profession has contributed a picayunish amount of money, in comparison to Federal and other funds, to carry on this fight, but the money has been our own, not taxpayers' money wrongfully expended.

* * *

The Federal District Court of Oregon has announced its findings in the Government's case against the Oregon State Medical Society. The Court fully and completely vindicated the society and found no guilt. Some of these notes bear a tone of optimism. The following is quoted from the judge's notes, upon which the final opinion will be written: "Can it be that a profession may not defend itself by reorganization of its methods, by doing within the profession what has been compelled elsewhere by law; that, to reorganize and seek to preserve its independent status makes an organized profession and its leaders criminals and subject to the injunctive power of the courts?

"In short, *that organized medicine must remain a sitting duck while socialism overwhelms it?* I would not expect an American court to hold that."

"Constitutional Democracy is not a one-way road. Those seeking changes, radical or otherwise, may urge them. Those who believe in things as they are or who seek to retain them in modified form may oppose radical change, without becoming subject to the criminal laws. That certainly

includes vitally interested parties whose way of living, whose living itself, is threatened. This is entirely aside from considerations of public interest."

* * *

But now, after the election the medical profession is vindicated. Commentators and news analists have credited the medical profession and the rural people for the setback which the progressing "welfare state" received. Opposition to the Brannan Plan, and to socialized medicine is credited with getting into the "Grass Roots" and bringing out the votes which retired some of the most active workers for the socialistic plans, and also gave our most active supporter a tremendous boost.

We are grateful for the results, and shall be on the alert for further "planned economy," "socialized medicine," "socialized agriculture," "socialized education," or others of the same ilk, all leading to the socialistic state.

PRESIDENT UMPHREY

ON SEPTEMBER 20, 1950, at Detroit during the Eighty-fifth Annual Session of the Michigan State Medical Society, Clarence E. Umphrey was installed as president. Dr. Umphrey was born March 9, 1896, graduated from High School, Yale, Michigan in 1915, and from Michigan State Normal College in 1917. He served in World War I from 1917-1918. He spent two years in Wayne University, premedical, and graduated from the Medical School in 1925. He was president of West Side Medical Society in 1931 and member of the Council, Wayne County Medical Society, 1935 to 1949. He was president of the Noonday Study Club, 1935-36, secretary of the Wayne County Medical Society, 1936-37, and president, 1937-38, then served five years on the Board of Trustees. He was president of the Wayne University College of Medicine Alumni, 1941-42. He has served on the Council, Michigan State Medical Society, 1938-49, when he was made president-elect. He was five years, 1944-49, on the Board of Directors of the National Physicians Association.

Dr. Umphrey's training for the surgical specialty was long and diverse: one year of internship in a teaching hospital, five years obtaining further surgical experience in a smaller hospital, one year on orthopedic staff and five years on the surgical outpatient staff at still another hospital. In 1945-46 he took a special basic science and surgical technique thirty-two-hour-per-week course for twelve months.

Dr. Umphrey is an untiring worker, as evidenced by his efforts on the Council, and his exhaustive study in the medico-economic and socialistic problems facing the country and the profession. His writings are extensive on that subject. Dr. Umphrey has attained F.A.C.S. and F.I.C.S., and this has all been accomplished while he was in the active practice of medicine. He is married and has two daughters.

ELECTIONS TO THE COUNCIL

AT THE ANNUAL meeting of the Michigan State Medical Society in Detroit, September 18-22, the following new officers were elected:

Duncan Bruce Wiley, Councilor 15th District, Utica, Michigan. He was born August 31, 1904, at Blenheim, Ontario. He had his premedical and medical training at the University of Western Ontario, London, Canada, and graduated in 1928. Internship at St. Joseph Hospital, Mt. Clemens, Michigan. He had postgraduate training at Cook County, Chicago, Illinois, 1928. He has practiced in Utica since 1929. He is a member of the Utica Rotary Club since 1929, and served as president, secretary, treasurer and director during that period. He was secretary of the Macomb County Medical Society and delegate of the Michigan State Medical Society for ten years. He has been on the National Conference of County Medical Society Officers, Michigan chairman since 1947, and has been area chairman for six states and member of the Executive Committee during that time. He is affiliated with St. Joseph Hospital in Mt. Clemens, Section of Obstetrics and Gynecology.

Wyman D. Barrett, Grosse Pointe, Michigan. Born in Canada, September 27, 1887. He was elected Councilor for the 16th District. His practice is in the David Whitney Building, Detroit, Michigan. He graduated at the University of Toronto in 1911. Internship at Harper Hospital, July, 1911, to July, 1913. He served twenty years with the late Dr. Angus McLean. He was a

first lieutenant in the first World War, doing surgery. He is now clinical professor of surgery at Wayne University Medical School. Has been president of the Detroit Academy of Medicine. He is chief of the Department of Surgery, Harper Hospital, consulting surgeon at St. Joseph's Mercy Hospital, Detroit Receiving Hospital, and Sigma Gamma Clinic, Detroit. He has published the following papers: "Primary Sarcoma of the Tongue," *Harper Hospital Bulletin;* "Multiple Primary Malignancies," *Harper Hospital Bulletin;* "Thyroid Carcinoma with Metastasis to the Groin," *Harper Hospital Bulletin;* "Multiple Primary Cancer—A study of Thirty-Six Patients," *Surgery, Gynecology and Obstetrics,* vol. 89, no. 6, December, 1949.

Robert Stevens Breakey, Councilor 2nd District, Lansing, Michigan. He was born August 10, 1898, at Ann Arbor, Michigan. He had his premedical and medical training at the University of Michigan, Ann Arbor, Michigan. Internship at University Hospital, Ann Arbor. He had postgraduate work at the University Hospital. He practiced at Ann Arbor (University Hospital) five years and at Grand Rapids one year. He has practiced at Lansing, since 1929. He is past president of Ingham County Medical Society, past president, Detroit Urological Society, member of American Urological Association, American Neisserian Medical Society, and past president, North Central Branch, American Urological Association. He is consultant in urology at E. W. Sparrow Hospital and St. Lawrence Hospital, Lansing, Michigan, and consultant, Memorial Hospital, Mt. Pleasant, Michigan, and St. Johns, Michigan.

George Willard Slagle, Councilor 3rd District, Battle Creek, Michigan. He was born September 1, 1909, Centerville, Ohio. He had his premedical and medical training at the University of Michigan, Ann Arbor, Michigan. Internship at Miami Valley Hospital, Dayton, Ohio, 1933 to 1934. Residency, Battle Creek Sanitarium in internal medicine, 1934 to 1937. Postgraduate training at Mayo Clinic, December, 1934, to December, 1935. Courses in American College of Physicians, 1939, 1941, 1946, 1947, and 1949. He was a Commander, M.C., U. S. Navy, during World War II, serving from December 13, 1941, to January 16, 1946. He is a member of the Citizens Committee of Battle Creek, director of Battle Creek Country Club and member of the Athelstan Club, member and Fellow of American College of Physicians, 1943, Calhoun County Medical Society, MSMS and AMA. He is affiliated with Leila Y. Post Montgomery Hospital, Community Hospital, and is consultant at Percy Jones General Hospital, Battle Creek, Michigan.

Reader Jenkins Hubbell, re-elected Councilor 4th District, Kalamazoo, Michigan. He was born September 8, 1896 at Wilmette, Illinois. He had his premedical and medical training at Northwestern University and graduated 1923. Internship at Wesley Memorial Hospital, Chicago, Illinois, 1922 to 1924. Postgraduate training with B.A. Thomas, M.D., Philadelphia, in urology, 1929 to 1930. He served in World War I as a private. He is a member of county, state and national medical associations, American Urological Association and is certified by the American Board of Urology. He has hospital affiliations with active staff, Borgess and Bronson Hospitals, Kalamazoo, Michigan, consulting staff of Kalamazoo State Hospital, Fairmont Hospital, Del Vista Sanitorium, Plainwell, Michigan. His most recent published paper is "Prostatic Surgery," JMSMS. He was vice chairman of the Council for three years.

Otto O. Beck, President-Elect, Birmingham, Michigan. He was born November 17, 1893, Grand Island, Nebraska. He had his pre-medical training at Central Wesleyan College, Warrenton, Missouri. Medical training at Missouri University and Northwestern University. Internship at Harper Hospital, Detroit, Michigan. He served in World War I as a private. He is a member of Birmingham Exchange, Trustee Michigan Hospital Service, Oakland County Medical Society, MSMS and AMA. He was medical director of Orenburg (Russia) District for the American Relief Administration, 1922, and chairman, MSMS Council. He is affiliated as a staff member with St. Joseph Mercy Hospital, Pontiac, Michigan.

THE MSMS RHEUMATIC FEVER CONTROL PROGRAM

MICHIGAN is believed to be the only state in the Union where a program for the control of rheumatic fever and rheumatic heart disease has been initiated and carried out under the auspices of the state medical society. In many other states

and localities rheumatic fever programs—the general need for which cannot be denied—have been sponsored by lay groups or by official agencies, frequently by-passing the role of the family physician.

The Michigan plan is based on the premise that the family doctor is the key person in any disease control program of this type because he is first to observe the first signs of illness and it is his responsibility to guide his patient to a successful recovery. The Michigan plan makes available to him—and through him to his patients—the use of its diagnostic and consultation facilities where he can obtain help and advice for his more troublesome cases, in management as well as in diagnosis.

Basically the plan is educational; it aims to make all physicians better diagnosticians, better clinicians and more expert in the difficult management of a notoriously long-term disease. It aims to educate the public in the early recognition of signs of illness and in early visit to the doctor for diagnosis.

For the patient the MSMS Rheumatic Fever Diagnostic and Consultation Centers offer a complete "work-up" by a group of qualified consultants, on referral by the family physician. No child in Michigan need forego the advantages of a thoroughgoing clinical and laboratory examination because the Rheumatic Fever Centers are strategically located throughout the state in the larger medical centers, within easy reach.

To the referring physician the Rheumatic Fever Centers render a complete report of the physical examination, laboratory findings and diagnosis of the board of examiners, together with specific advice on management. The patient remains his patient to care for and look after. In many cases the Centers have acted as a sort of court of appeals, perhaps confirming or denying a diagnosis (sometimes forced by the parent), perhaps supporting the referring physician's recommendation for such procedures as tonsillectomy or convalescent care.

To the consultants who actually work in the Center — pediatricians, cardiologists, radiologists and others—it affords an opportunity to study a greater number of cases in more detail, and to discuss their findings with their colleagues. Rheumatic fever often is a baffling disease and each case is likely to pose a number of problems for solution.

The Rheumatic Fever Diagnostic and Consultation Centers can be of inestimable value to the practicing physician in the diagnosis and care of rheumatic fever and rheumatic heart disease. The success of the program depends on the active support by every member of the profession, either by referring their difficult cases to the Centers or by participating in the operation of the Centers. It shall not be said that the doctors are incapable of concerted effort and action.

L. D. V.

MSMS

THE ACUTE RHEUMATIC STATE

(Continued from Page 1419)

cardiac catheterization will prevent undue hazard in diagnosis. The functional murmur and/or neurocirculatory asthenia in the older child are probably the conditions most often confused with the mild or smoldering active rheumatic fever. Close and long clinical observation with the use of all laboratory aids, psychiatric consultation will finally decide the issue; nevertheless the nervous child with rheumatic fever may be frequently co-existent.

Other Conditions.—There are many unrelated diseases having some clinical attributes of rheumatic fever. Indeed their number may be as large as the perspicacity of the examiner. For example poliomyelitis early masquerades at times as rheumatic fever, but this disease actually does not give as much arthralgia as myalgia; the differential especially with spinal tap offers little difficulty. Typhoid fever is another acute infection with myalgia, arthralgia, even arthritis; course, cultures, Widal, effect of chloromycetin clarifies the problem. Other infections that occasionally offer diagnostic problems are bacillary dysentery, meningitis, especially meningococcic, and brucellosis; the latter if unsuspected may "pass" for a long period as rheumatic fever. Sickle cell anemia and leukemia often give arthralgias and murmurs but hemogram and bone marrow easily clinch these diagnoses. We have already mentioned the possible confusion of acute appendicitis and the peritoneal manifestation of acute rheumatic fever.

The national health service drew the line at buying Britons their bath salts. Neither, said the health ministry, will it honor prescriptions for lotions to make mosquitoes go away. This also applies to vanishing cream, shaving soap, tooth paste, talcum powder, and hair tonic. (*Chicago Daily Tribune,* Aug. 5, 1950.)

Second Michigan Industrial Health Day

April 4, 1951

Rackham Memorial Bldg.
100 Farnsworth Ave.
Detroit 12, Michigan

Sponsored by the Michigan Association of Industrial Physicians and Surgeons; Wayne University College of Medicine; Michigan State Medical Society's Committee on Industrial Health; Division of Industrial Health of the Michigan Health Dept.; Medical School of the University of Michigan; Michigan State Association of Industrial Nurses; the School of Public Health of the University of Michigan, and the Michigan Industrial Hygiene Society.

General Chairman for the Day
CARL HANNA, M.D., Detroit

PRELIMINARY PROGRAM

Morning Session

A.M.

9:00 **Registration:** Rackham Memorial Bldg., Main Auditorium.

9:30 **"Introduction To the Day's Activities."**
Presiding, CLIFFORD H. KEENE, M.D., Medical Director, Kaiser-Frazer Corp., Willow Run, Michigan.

9:40 **"New Developments in Industrial Surgery."**
HARRY E. MOCK, JR., M.D., Northwestern University, College of Medicine, Department of Surgery, Chicago, Illinois.

10:00 **"Developments in Industrial Nursing."**
HELEN DE COURSEY, R.N., Kelsey Hayes Wheel Company, Detroit.

10:20 **"The Rising Toll of Obesity in Industry."** America's number one health problem.
ALFRED W. PENNINGTON, M.D., Medical Department, E. I. DuPont Co., Wilmington, Delaware.

10:40 **"Beryllium Poisoning."** The newest major occupational disease.
OSCAR A. SANDER, M.D., Marquette University, College of Medicine, Milwaukee, Wisconsin.

11:00 **"International Industrial Medicine."** The United States is carrying Industrial Medicine to other lands.
ROBERT C. PAGE, M.D., General Medical Director, Standard Oil Co. of New Jersey, New York, N. Y.

11:45 **Discussion Leader:**
GORDON H. SCOTT, PH.D., Dean of Medical College, Wayne University, Detroit, Michigan.

P.M.

12:00-2:00 **Lunch Period:** (The dining-rooms of nearby Sheraton Hotel are readily accessible)

Afternoon Session

Presiding, HARLEY L. KRIEGER, M.D., Medical Director, Ford Motor Co., Dearborn, Michigan.

P.M.

2:00 **"Defenses Against Atomic Bombing."**
DONALD S. LEONARD, Director of Civil Defense, East Lansing, Michigan.

3:00 **"Medical Responsibilities in Atomic Bombings."**
JAMES H. STERNER, M.D., Associate Medical Director, Laboratory of Industrial Medicine, Eastman Kodak Co., Rochester, N. Y.

4:00 **Discussion Leader and Demonstrator of Radio Activity Measurement Equipment.**
HOMER S. MYERS, Vice President, Radioactive Products, Inc., Detroit, Michigan.

4:30 **Annual Business Meeting**—Michigan Association of Industrial Physicians and Surgeons.
Presiding, JOSEPH L. ZEMENS, M.D., President of the Michigan Association of Industrial Physicians and Surgeons, Detroit, Michigan, Rackham Memorial Building.

Evening Sessions

6:00 **Cocktails:** Available in the Sheraton Hotel.

Annual Banquet (informal)

7:00 Toastmaster—CLARENCE E. UMPHREY, M.D., President, Michigan State Medical Society, Detroit, Michigan.

"The Industrial Worker's Better World."

LILLIAN M. GILBRETH, M.D., Consulting Industrial Engineer, Montclair, New Jersey.

The Inauguration of the Twenty-Five Years Occupational Health Service Group, and the Presentation of Certificates. JOSEPH L. ZEMENS, M.D., presiding.

All members of the Michigan State Medical Society are cordially invited to attend.

The Michigan Heart Association

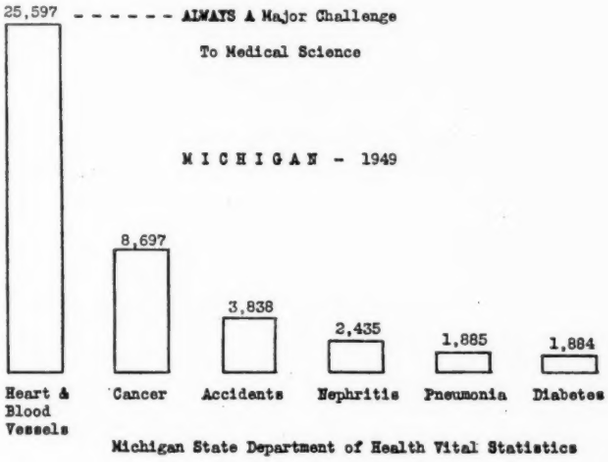
A Story of Dynamic Progress

THE Michigan Heart Association, in a little more than a year of operation, has become one of the major front line organizations in the nation today fostering studies in America's number one health problem—heart disease. During the past several months the Michigan Heart Association has written a dramatic story of what can be accomplished by concerted co-operative effort toward the control of heart disease in Michigan.

In order that we may fully appreciate the time and effort expended in organizing an association to fight heart disease in this state, it is necessary to briefly review the origin of the Michigan Heart Association from the first informal organizational meeting in the summer of 1948 to February, 1949, when the Michigan Heart Association was officially incorporated as a nonprofit organization under the laws of the State of Michigan.

Prior to the formation of a heart association in Michigan, the only organization in the state conducting activities into the problems of heart disease and rheumatic fever was the Michigan State Medical Society. The medical society exchanged considerable correspondence with the American Heart Association concerning the possibility of forming a Michigan Heart Association, representative of both professional and lay groups, which would be able to conduct a broader and more continuous campaign against diseases of the heart and circulation.

Accordingly, on August 11, 1948, the first informal meeting, to consider the need for the formation of a Michigan Heart Association, was held in Lansing, Michigan, under the chairmanship of L. Fernald Foster, M.D., of Bay City, secretary of the Michigan State Medical Society. In addition to Dr. Foster, the meeting was attended by Carleton Dean, M.D., director of the Michigan Crippled Children Commission; Warren B. Cooksey, M.D., Detroit Heart Club; Frank Van Schoick, M.D., chairman, Rheumatic Fever Control Committee of the Michigan State Medical Society; P. L. Ledwidge, M.D., H. H. Riecker, M.D., E. I. Carr, M.D., L. P. Ralph, M.D., members of the Michigan State Medical Society; Mrs. Hugh Wilson; and Messrs. W. Pierce and Earl Lippincott of the United Health and Welfare Fund of Michigan. After various aspects of the formation of a heart association were discussed, the group recommended to the Council of the Michigan State Medical



Society "that it proceed at once with plans to organize a Michigan Heart Association." A committee, from those present, was appointed to meet with delegates of the American Heart Association on September 18, 1948, to discuss the Michigan project and to develop plans for future co-operation with the national organization.

Shortly thereafter, E. F. Sladek, M.D., president of the Michigan State Medical Society, acting under instructions from the Council of the medical society, appointed a committee to organize a Michigan Heart Association. This committee met in Lansing, Michigan, on November 3, 1948, at which time Dr. L. F. Foster reviewed the work of the Michigan Rheumatic Fever Control Program from 1945 through 1948. Dr. Foster praised the Michigan Society for Crippled Children and Adults, Inc., for its generous aid in providing financial support to the Rheumatic Fever Program during this three-year period. He also pointed out that greater advantage would accrue to the people of Michigan through the formation of a Michigan Heart Association and that through affiliation with the American Heart Association, a continuous program in the study of heart disease could be inaugurated in Michigan.

Warren B. Cooksey, M.D., of Detroit, was elected chairman of this organizational committee, and plans were made for the immediate formation of a Michigan Heart Association.

The second meeting of the organization committee met on December 22, 1948, and the name "Michigan Heart Association" was officially adopted. Through unanimous approval, the committee also voted that the Articles of Incorporation be filed with the Michigan Securities and Exchange Commission.

Through the generosity of the Wayne County Medical Society, office space was made available to the Michigan Heart Association at the David Whitney House, headquarters of the Wayne County Medical Society, 4421 Woodward Avenue, Detroit. Headquarters of the Michigan Heart Association have been maintained at this address at a very minimal cost.

When the final meeting of the organization committee was held in Detroit on January 26, 1949, its ranks had been considerably enlarged through the addition of a number of interested lay persons. The Articles of Incorporation were signed by the members of the organization committee at this eventful meeting.

The signers of the Articles of Incorporation were unanimously elected to the first Board of Trustees of the Michigan Heart Association, and it held its initial meeting immediately following the last meeting of the organization committee. Mr. C. E. Wilson, president of the General Motors Corporation, was elected chairman of the Board of Trustees and the following officers were also elected: president, W. B. Cooksey, M.D.; president-elect, Paul Barker, M.D.; vice president, Frank Van Schoick, M.D.; vice president, Bethany L. Wilson; secretary, L. Fernald Foster, M.D.; treasurer, Charles T. Fisher, Jr. In addition, an Executive Committee and a Finance Committee were appointed.

Mr. Frank Isbey, as a member of the Finance Committee, was charged with the responsibility of implementing a drive for funds in co-operation with the United Health and Welfare Fund and the United Foundation.

Plans were also authorized by the Board of Trustees for the secretary to make application to the American Heart Association for affiliate membership.

On February 17, 1949, the Michigan Heart Association was officially incorporated as a non-profit organization under the laws of the State of Michigan.

A few months later, on July 1, 1949, the Michigan Heart Association became an official affiliate of the American Heart Association. Under the affiliation agreement the Michigan Heart Association contributes 25 per cent of all funds received to the national association for use in research and educational programs in the cardiovascular field. In return, the people of Michigan and the Heart Association of this state will share in and benefit from the activities of the American Heart Association.

It is also important to point out that the Michigan Heart Association is a member agency of the United Health and Welfare Fund of Michigan (United Foundation in Detroit) and, as such, co-operates with other nonprofit agencies throughout the state in a united appeal for funds.

Since February of 1949 the funds contributed to the Michigan Heart Association by the people of Michigan have made possible the financial sponsorship of twenty vital research, education, and community service projects in diseases of the heart, eighteen of which are currently being conducted in our state. During the 1950-1951 fiscal year, the Michigan Heart Association has allocated approximately $108,000.00 for various projects. More than half of this amount has been assigned to medical schools, hospitals and other institutions throughout Michigan for research studies in diseases of the cardiovascular system (See Page 1401.).

The balance has been designated by the Association for the use of educational and community service projects, such as the Rheumatic Fever Control Program of the Michigan State Medical Society (the Rheumatic Fever Program also receives financial aid from the Michigan Society for Crippled Children and Adults and the Michigan Chapter of the Arthritis and Rheumatism Foundation). Other educational and community service projects include the Industrial Cardiology Program, the Cardiac Housewife Program and the Association's public information program.

The Cardiac Housewife Program, a study of work simplification in the home to develop ways and means of conserving the time and energy of the housewife whose working capacity is limited by heart disease, has met with dynamic success. The Michigan Heart Association is now offering classes in work simplification to any woman with a

cardiac disorder at no cost whatsoever to the patient. The classes are made possible through funds received from the United Fund Campaigns over the state. The course of instruction is based upon an extensive six-month study conducted by the heart association in co-operation with the Home Economics Department of Wayne University. Plans are presently being developed to extend this service to every community in Michigan through the Department of Home Economics at Michigan State College.

The Association's Public Information Program is designed to increase public understanding of heart disease. The program provides the people of Michigan with information relative to the care of their hearts and the new medical and surgical techniques being perfected for the benefit of the heart patient. It also keeps the public informed of the many research, educational, and community service projects being supported, in whole or in part, by the Michigan Heart Association.

Doctors of medicine (and as a result, the people of Michigan) also benefit from this program by receiving the very latest scientific information regarding current advances in the diagnosis, treatment and control of heart disease.

It is important to remember, however, that each and every project contributes in full measure to the care, diagnosis or treatment of all heart patients and that the continuation of these research, education, and community service projects is dependent upon funds received by the Michigan Heart Association from the United Fund Drives.

Progress in any field of endeavor has a price tag. For instance, industrial progress. It cost millions to develop today's modern, efficient, mass-production industrial plants. It also took millions to develop jet propulsion, radar and other momentous technical marvels of our time.

Medical progress has a price tag, too. The conquest of past scourges like diphtheria, typhoid fever and smallpox, which fifty years ago snuffed out so many hundreds of lives, took money. The discovery and mass production of such drugs as penicillin and sulfa—powerful agents against infections—took money—and a lot of it.

It is only inevitable then, that progress in the work against heart disease, this country's number one health problem, is also geared to the expenditure of money. Future progress of the Michigan Heart Association will be governed by the response of the professional and lay people of Michigan in meeting the challenge of heart disease. The fight to combat mankind's supreme enemy, heart disease, can only be won by paying the price of progress. Its conquest will be one of mankind's greatest triumphs.

The essential and beneficial projects currently being conducted by the Michigan Heart Association provide a few significant examples of recent successes. These projects are sign posts along the highway of progress pointing to a more hopeful future for those afflicted so that they may live longer, happier and more useful lives.

MICHIGAN HEART ASSOCIATION

Officers and Committees

1950-1951

President	Paul S. Barker, M.D.
President-elect	Douglas Donald, M.D.
Vice President	Frank Van Schoick, M.D.
Vice President	Mrs. Hugh Wilson
Secretary	L. Fernald Foster, M.D.
Treasurer	Mr. Charles T. Fisher, Jr.
Chairman of the Board	Mr. Charles E. Wilson
Executive Secretary	Leon DeVel, M.D.

BOARD OF TRUSTEES

Term to Expire 1951

Ernest Kanzler	*Leon DeVel, M.D.
C. F. Kettering	*Douglas Donald, M.D.
Endicott R. Lovell	*L. Fernald Foster, M.D.
Mrs. W. W. MacGregor	A. W. Lescohier, M.D.
C. J. Reece	Rudolph R. Light, M.D.
*Emmet Richards	F. D. Dodrill, M.D.
*Carleton Dean, M.D.	

Term to Expire 1952

*S. E. Skinner	C. D. Selby, M.D.
H. M. Taliaferro	Milton Shaw, M.D.
Herman L. Weckler	Henry L. Smith, M.D.
*C. E. Wilson	*Frank Van Schoick, M.D.
Otto G. Wismer	*Mrs. Hugh Wilson
*L. Paul Ralph, M.D.	*F. Janney Smith, M.D.
H. H. Riecker, M.D.	E. F. Sladek, M.D.

Term to Expire 1953

Mrs. Harold R. Boyer	M. S. Chambers, M.D.
*Frank N. Isbey	L. T. Colvin, M.D.
Harvey Campbell	*Warren B. Cooksey, M.D.
W. H. Doerfner	Moses Cooperstock, M.D.
Henry Fink	Cecil Corley, M.D.
*Charles T. Fisher, Jr.	C. G. Darling, M.D.
*Paul S. Barker, M.D.	

*Executive Committee of the Board of Trustees.

Program Committee

Carleton Dean, M.D., *Chairman*
George Graybiel, M.D.
Max R. Burnell, M.D.
Warren B. Cooksey, M.D.
Henry L. Smith, M.D.
Myer Teitelbaum, M.D.
Mrs. Hugh Wilson
Paul S. Barker, M.D., (ex officio)
Douglas Donald, M.D., (ex officio)

Finance Committee

Frank Isbey, *Chairman*
Charles T. Fisher, Jr.
S. E. Skinner
Paul S. Barker, M.D., (ex officio)
Douglas Donald, M.D., (ex officio)

Medical Advisory Committee

F. Janney Smith, M.D., *Chairman*
C. D. Selby, M.D.
F. D. Dodrill, M.D.
Franklin Johnston, M.D.
L. Paul Ralph, M.D.
Paul S. Barker, M.D., (ex officio)
Douglas Donald, M.D., (ex officio)

Membership Committee

H. H. Riecker, M.D., *Chairman*
Milton Shaw, M.D.
F. D. Dodrill, M.D.
Paul S. Barker, M.D., (ex officio)
Douglas Donald, M.D., (ex officio)

Committee on Cardiovascular Clinics

Douglas Donald, M.D., *Chairman*
Frank Van Schoick, M.D.
M. S. Chambers, M.D.
Cecil Corley, M.D.
E. F. Sladek, M.D.
Paul S. Barker, M.D., (ex officio)
Douglas Donald, M.D., (ex officio)

Committee on Occupational Cardiology

Warren B. Cooksey, M.D., *Chairman*
F. Janney Smith, M.D.
E. A. Irvin, M.D.

MICHIGAN HEART ASSOCIATION

The Michigan Heart Association is a voluntary agency interested in the problems of diseases of the heart and blood vessels. Its program is one of education, research, and community service. The Michigan Heart Association is a member agency of the United Health and Welfare Fund.

The Articles of Incorporation of the Michigan Heart Association state, in part:

"The study of and acquisition, dissemination, and application of knowledge concerning the normal heart and circulation, and the causes, diagnosis, prevention, and treatment of disorders of the circulation and diseases of the heart, blood vessels and lymph vessels; the development and application of knowledge that will prevent such disorders and diseases; the gathering and publication of information upon all aspects of such disorders and diseases; including studies of occupations suitable for patients with diseases or disorders of the heart or circulation; the encouragement of the establishment of special dispensary facilities for patients with such diseases, and of facilities for adequate convalescent care of such patients and the promotion of permanent institutional care for such of them as are hopelessly incapacitated for self-support; and the encouragement, establishment and assistance of local associations and committees with similar purposes and to do any and all acts, necessary, convenient or proper in furtherance of the aforesaid purposes and objects, provided, however, that this corporation shall not be empowered to carry out any purpose or object or to do any act in pursuance thereof involving pecuniary gain or profit for its members or associates."

Membership in the Michigan Heart Association includes membership in the American Heart Association.

Members of the Michigan State Medical Society are invited to join.

MICHIGAN HEART ASSOCIATION
4421 Woodward Avenue
Detroit 1, Michigan

APPLICATION FOR ANNUAL (VOTING) MEMBERSHIP

NAME .....
(Please Print)

ADDRESS .....

CITY ..... ZONE .....

Annual (Voting) Membership, including a subscription to "Modern Concepts of Cardiovascular Disease."..... $ 5.00 ☐

Annual (Voting) Membership, including a subscription to "Modern Concepts of Cardiovascular Disease" plus a one-year subscription to "CIRCULATION" (the official organ of the American Heart Association)..... $15.50 ☐

.....
(Signature)

Please make check payable to the Michigan Heart Association.

FIFTH ANNUAL MICHIGAN POSTGRADUATE CLINICAL INSTITUTE AND HEART DAY

Detroit—March 14-15-16-17, 1951

ENTERTAINMENT PROGRAM

Wednesday, March 14, 1951, 8:30 p.m. to 1:00 a.m.
Grand Ballroom, Book-Cadillac Hotel, Detroit

1. **DON LARGE and his FIVE GRENADIERS**—Finest choral group of its kind in the business today. Five voices—varied repertoire of solos and quintette numbers—colorful wardrobe.
2. **REG THORNTON and his ORCHESTRA**—Detroit's outstanding band playing South American as well as the sweet numbers.
3. **THE OLD-TIMERS**—Gay music for Square Dances and Quadrilles—with a caller for the sets who gives an outline of the steps of each dance—Loads of fun for beginners and experts in Square Dancing.

All registrants and their ladies are cordially invited to attend.

No admission fee—merely show your registration badge.

HOST: MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

* * * * * * *

HOTEL RESERVATION BLANK

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to C. B. Loftis, Front Office Manager, Book-Cadillac Hotel, Detroit, Michigan. Mailing your application now will be of material assistance in securing good hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when possible.

Committee on Hotels,
Michigan State Medical Society,
c/o C. B. Loftis,
Book-Cadillac Hotel,
Detroit 31, Michigan,

Please make hotel reservation(s) as indicated below:

.....Single Room(s)

.....Double Room(s) for ..... persons

.....Twin-Bedded Room(s) for .....persons

Arriving March .....hour.....A.M.....P.M.

Leaving March .....hour.....A.M.....P.M.

Hotel of First Choice: .....

Hotel of Second Choice: .....

Names and addresses of all applicants including persons making reservation:

Name	Address	City	State

Dates ..... Signature .....

Address ..... City .....

Table of Contents

MICHIGAN STATE MEDICAL SOCIETY

Eighty-fifth Annual Session

DIGEST OF PROCEEDINGS OF THE HOUSE OF DELEGATES

MONDAY MORNING SESSION

September 18, 1950

The first meeting of the House of Delegates, Michigan State Medical Society, convened at the Book-Cadillac Hotel, Detroit, Michigan, September 18, 1950, at 10:15 a.m., R. H. Baker, M.D., Pontiac, Speaker, presiding.

I. Record of Attendance

Office	*Officer*	*Meetings* 1st	2nd	3rd	4th
Speaker	R. H. Baker	x	x	x	x
Vice Speaker	J. E. Livesay	x	x	x	x
Secretary	L. Fernald Foster	x	x	x	x
Immediate Past President	E. F. Sladek	x	x	x	x
County	*Delegate*				
1. Allegan	L. F. Brown	x	x	x	x
2. Alpena-Alcona-Presque Isle	E. S. Parmenter	x	x	x	x
3. Barry	A. B. Gwinn	x	x	x	–
4. Bay-Arenac-Iosco	O. J. Johnson	x	x	x	x
	W. S. Stinson	x	x	x	–
5. Berrien	D. W. Thorup	x	x	x	x
6. Branch	R. L. Wade	Not	Represented		
7. Calhoun	H. C. Hansen	x	x	x	x
	G. W. Slagle	x	x	x	x
8. Cass	S. L. Loupee	Not	Represented		
9. Chippewa-Mackinaw	B. T. Montgomery	x	x	x	x
10. Clinton	F. W. Smith	x	x	–	–
11. Delta-Schoolcraft	W. A. LeMire	x	x	x	x
12. Dickinson-Iron	D. R. Smith	x	x	x	x
13. Eaton	G. C. Stucky	x	x	x	–
14. Genesee	F. A. Barbour	–	–	x	x
	F. W. Baske	x	x	x	x
	C. W. Colwell	x	x	x	x
	F. D. Johnson	x	x	–	–
	C. K. Stroup	x	x	x	x
15. Gogebic	J. R. Franck	x	x	x	x
16. Grand Traverse-Leelanau-Benzie	D. G. Pike	x	–	x	x
17. Gratiot-Isabella-Clare	M. G. Becker	x	x	x	x
18. Hillsdale	L. W. Day	x	x	x	x
19. Houghton-Baraga-Keeweenaw	T. P. Wickliffe	x	x	x	x
20. Huron	C. W. Oakes	x	x	x	x
21. Ingham	R. S. Breakey	x	x	x	x
	L. G. Christian	x	x	x	x
	H. W. Wiley	x	x	x	x
22. Ionia-Montcalm	W. L. Bird	x	x	x	x
23. Jackson	E. H. Corley	x	x	x	x
	J. D. Van Schoick	x	x	x	x
24. Kalamazoo	R. J. Armstrong	x	x	x	x
	W. A. Scott	x	x	x	x
	R. W. Shook	x	x	x	x
25. Kent	L. C. Carpenter	x	x	x	x
	G. W. DeBoer	x	x	x	x
	J. W. Logie	x	x	x	x
	W. B. Mitchell	x	x	x	x
	A. A. Van Solkema	x	x	x	x
	A. V. Wenger	x	x	x	x
26. Lapeer	D. J. O'Brien	x	x	x	x
27. Lenawee	R. E. Dustin	x	x	x	x
28. Livingston	H. C. Hill	x	x	x	x
29. Luce	E. H. Campbell	Not	Represented		
30. Macomb	D. B. Wiley	x	x	x	x
31. Manistee	E. B. Miller	x	x	x	x
32. Marquette-Alger	N. J. McCann	Not	Represented		
33. Mason	E. B. Boldyreff	Not	Represented		
34. Mecosta-Osceola-Lake	David N. Kilmer	x	x	x	–
35. Menominee	J. R. Heidenreich	x	x	x	x
36. Midland	R. S. Ballmer	Not	Represented		
37. Monroe	T. A. McDonald	x	x	x	x
38. Muskegon	R. D. Risk	x	x	x	x
	N. W. Scholle	x	x	x	x
39. Newaygo	B. L. Masters	x	x	x	x
40. North Central	C. G. Clippert	x	–	x	–
41. Northern Michigan	J. R. Rodger	x	x	x	x
42. Oakland	E. B. Cudney	–	–	x	x
	H. A. Furlong	–	x	x	–
	C. R. Gatley	x	x	x	x
	J. M. Markley	x	x	x	x
	P. E. Sutton	x	x	x	–
43. Oceana	W. G. Robinson	–	–	x	–
44. Ontonagon	W. F. Strong	x	–	x	x
45. Ottawa	K. N. Wells	x	x	x	x
46. Saginaw	C. E. Toshach	x	x	x	–
47. Sanilac	R. K. Hart	Not	Represented		
48. Shiawassee	C. L. Weston	x	x	x	x
49. St. Clair	W. H. Boughner	x	x	x	x
50. St. Joseph	R. A. Springer	x	x	x	x
51. Tuscola	L. L. Savage	x	x	x	x
52. Van Buren	W. R. Young	x	x	x	x
53. Washtenaw	P. S. Barker	x	x	x	x
	O. K. Engelke	x	x	x	x
	B. M. Harris	x	x	x	x
	H. H. Riecker	–	x	x	x
	R. W. Teed	x	x	x	x
54. Wayne	W. W. Babcock	x	x	x	x
	H. E. Bagley	x	x	–	–
	D. C. Beaver	x	x	x	x
	C. D. Benson	–	–	–	x
	E. A. Bicknell	x	x	x	x
	O. A. Brines	x	x	x	x
	W. L. Brosius	x	x	x	x
	C. L. Candler	x	x	x	x
	E. G. Cochrane	x	–	x	x
	M. A. Darling	x	x	x	x
	H. F. Dibble	x	x	x	x
	E. F. Dittmer	x	x	x	x
	Douglas Donald	x	x	x	x
	H. B. Fenech	x	x	x	x
	E. H. Fenton	x	x	x	–
	R. F. Fenton	x	x	x	x
	C. K. Hasley	x	x	x	x
	L. T. Henderson	x	x	x	x
	D. H. Kaump	x	x	x	x
	E. D. King	x	x	x	x
	E. G. Krieg	x	x	x	x
	H. J. Kullman	x	x	x	x
	J. J. Lightbody	x	x	x	x
	J. E. Lofstrom	x	x	x	x
	E. C. Long	x	x	x	x
	K. M. McColl	x	x	x	x
	N. D. McGlaughlin	x	x	x	x
	G. T. McKean	x	x	x	x
	J. G. Molner	x	x	–	x
	L. J. Morand	x	x	x	x
	R. L. Novy	x	x	x	–
	C. I. Owen	x	x	x	x
	G. C. Penberthy	x	x	x	x
	A. Hazen Price	x	x	x	x
	C. S. Ratigan	–	x	x	x
	W. S. Reveno	x	x	x	–
	J. H. Schlemer	x	x	x	x
	E. D. Spalding	x	x	x	x
	E. C. Texter	x	x	x	x
	Arch Walls	x	x	x	–
	F. A. Weiser	x	x	x	x
55. Wexford-Missaukee	R. V. Daugharty	–	–	x	–

THE SPEAKER: At this time I would like us to take cognizance of the fact that 118 of the members of the Michigan State Medical Society have died since last year's session. The list is so great I will not read their names. However, not the least among these is the name of our past Speaker of the House for five years, President of the Michigan State Medical Society, and a worker whom we all admired, loved and revered, Dr. P. L. Ledwidge. May I ask you at this time to stand for a moment in silence in memory of these gentlemen?

(The House of Delegates arose for a moment of silence.)

THE VICE SPEAKER: It is my pleasure at this time to introduce to you R. H. Baker, M.D., of Pontiac, Speaker of the House of Delegates.

II. Speaker's Address

By R. H. Baker, M.D., Pontiac

Each year, your speaker is given this opportunity to address you. My remarks shall be at random, in reference to problems facing our profession. Some of these we are now meeting actively. Some will be approached by resolution at this session of the House of Delegates and some we just ponder and perhaps have prepared no solution.

I am particularly mindful of the stimulating leadership and provocative suggestions made by your Speakers in the last four years, and of the officers who addressed you at these sessions of the House. I find, in reviewing their remarks, that we are all thinking along the same lines, because we all have, in some way, faced many of the challenges enumerated. But each of us, in our proud individualism, may arrive at somewhat different solutions for the same problem. And each gives different weight to them.

The onset of open war in Korea and its threatened implications, may seem to have put aside the immediate threat of the Compulsory Health Insurance sponsors.

I am still greatly concerned, whether we are meeting this threat of State Controlled Medical Practice to the best advantage. Some very thoughtful citizens in the United States sincerely believe that if Voluntary Hospital and Medical Insurance is good, then complete coverage by a Government Sponsored—Tax Supported—Insurance Program, will answer better, the many problems of cost and distribution of which we are well aware.

I am proud that Michigan is in the vanguard in answer to this philosophy of government medicine. We have gone far in answering the criticism that medical security is not available under a Voluntary Insurance program. We have extended our coverage to medical care in hospitals and extended our policies to four times the period originally covered by Blue Shield.

A few figures should be of interest. During the year 1939—medical coverage under Voluntary Insurance in the United States increased 31 per cent. In ten years Blue Cross has grown from less than 4.5 million to 34 million.

Commercial coverage on Medical and Surgical Insurance, the last 10 years, increased 14.9 million. In the same period—Blue Shield increased 14.5 million.

Medical coverage, alone, increased 2.7 million in commercial coverage, and 8.5 million through Blue Shield.

And now there are seventy-one doctor-sponsored plans in the United States and Territories.

These figures alone should be ample proof of the ability of Private Enterprise in Medical Practice, to provide and extend medical care to the American people, and their acceptance in such increasing numbers confirms their ability to pay.

The advocates of Federal Medicine are sure this proposed system is best. They claim, only by a tax supported medical scheme can the nation be covered. We doubt the nature of medical care under such a program. And we challenge the cost and method of administration of Federal Bureaucratic medicine.

In a recent article by Rebecca West *(Ladies Home Journal,* September, 1950) entitled—"Can a Nation Afford Health for All Its People," the author makes a frank appraisal of the British National Health Service. She emphasizes one of the greatest faults in their plan was *lack* of *time* to properly plan. And she warns of the errors that are inevitable when any political party —hurriedly launches a Health Service plan and then, when their term of power in office is limited—they become staunch defenders of their plan *including* all its faults.

I have always maintained we should be cautious in making too close comparisons between British and American Medical Practice. I think this article will explain my point—Britain had reasons for adopting their plan. How far are their basic reasons applicable to the United States? In the body of this article the Editors have inserted this quotation: "Reformatory measures are hailed as cure-alls by people who have a happy confidence in the perfectibility of human nature, and no discouraging acquaintance with history to dim it." This quotation reminds me of one from Patrick Henry—"I have but one lamp by which my feet are guided, and that is the lamp of experience. I know of but one way of judging the future, and that is by the past." I believe we have some past experience in America and abroad—by which to judge the future in Medical Practice. But if it be true that we are near to embarking on a brand new experiment in America let us heed Rebecca West's advice and take *time* to study and plan.

I am one who, in recent years, has modified a "stand pat" individualism for a more flexible concept. Evolution of our social thinking forces us to such changes. We in Michigan Medicine, were pioneers in this changing thought (I claim no credit for my early conservatism in appraising the Blue Shield movement).

I feel no disgrace in being conservative. We might all judge ourselves as being in one of these categories:

Reactionary—one who would fight progress and return to the past.

Conservative—one who would value the best we have and try to retain it.

Progressive—the conservative who while retaining the good of today is alert to social, scientific and economic progress.

Radical—one who would destroy all we have and offer nothing tangible in return. American doctors are conservative, but their medical practice is progressive.

I go along with our present expanding effort to meet the demands of health care by Voluntary Insurance—but I invite your thoughtful consideration of all points of view in charting our forward course.

What are some of the considerations focused in the public mind, by this major conflict in these philosophies concerning medical care to the nation? I will briefly mention some we are attacking actively and some which must continue to carry our concerted effort.

Our Public Relations program must continue—continue to educate the public on the good things in medicine and its present practice—that must be conserved. But let's keep our efforts in this direction—*factual*—not fallacy. Let's have no propaganda that is camouflage —"like the bustle designed to cover stern reality."

We must progress—in our efforts, through grievance and mediation committees, to meet the demands of *fair dealing*—this will take much courage and leadership, and some vigorous policing within our own ranks. Policing of our profession is *not* a function of insurance carriers. Honesty and integrity must prevail over those tempted by new avenues of financial gain which are opened by extention of medical Insurance coverage.

Our ethics must be kept modernized.

We must continue our efforts to provide more and better doctors (and incidentally keep the public informed of those efforts). (A resolution on this will appear before this body.)

We must exert any influence we possess to solve the problem of the shortage of nurses, the length and character of their training and the resulting cost of their services to the public. The profession of nursing is passing through the same "growing pains"—that medicine faced with the standardization of Medical Schools and Hospitals. Perhaps a bit of history can help them light the way. They might review the earlier concept of a nurse and her relation to the patient and his doctor in

charting their course for the present and future in the training and supply of nurses.

And not the least of our current consideration must be our relations with other practitioners of the Healing Art.

In all of our considerations we must be mindful of the availability, quality and cost of medical care. That means a better knowledge of Blue Shield by all physicians—of Blue Cross and what makes hospitals costs rise. It means—unbiased encouragement in meeting the Rural Health Center and hospital problems. It means careful study of medical licensure. And it means more interest and activity by the doctors back home, whom you and I represent—and their knowledge and appraisal of our efforts here in behalf of our profession and the public good.

Gentlemen, you will attack many of these considerations, at this convention by resolutions and discussion. Let us have *"noisy argument"* if you will, but not *"silent grudge."* We may rush our decisions, or we may go slow—but let us not stand still.

THE VICE SPEAKER: The Speaker's Address will be referred to the Reference Committee on Officers' Reports.

THE SPEAKER: It is my very great pleasure to introduce to you President W. E. Barstow, M.D.

III. The President's Address

By W. E. Barstow, M.D., St. Louis

It is customary at this time to summarize briefly the work of the Michigan State Medical Society for the past year. If these remarks act to any extent as a springboard or catalyst for your consideration of current problems, they will have served their purpose.

It is impossible to single out for mention each aspect of committee activity in the time available. The handbooks in your possession contain committee reports in full to permit a later detailed study. It is desirable now merely to highlight the program now ending.

Last year's House of Delegates empowered us to purchase or construct a building to house the Societies offices. Like the usual discouraged home buyer, we have been unsuccessful, but at least we have not been rash. Suitable buildings have been located, but none at a reasonable price. Suitable land for construction is unavailable. We can only hope that conditions will change in the future.

The Public Relations activities of our Society are constantly expanding. With the assistance of Hugh Brenneman, one of our outstanding medical public relations advisors in the country today, our program has consistently led the field. The CAP program has met with sufficient success to warrant re-emphasis and even greater efforts in the future. Medication of problems arising from physician-patient relationship has already shown promise of clearing away a former source of public dissatisfaction.

The fine work of our Legislative Committee in encouraging constructive state legislation, and the efforts of the Committee on Distribution of Medical Care, have aggressively attacked other aspects of public relations. Successful public relations require an integrated and forward-looking program. We believe we are reaching every feasible area of activity.

The committee work on specific health problems has been too extensive to even outline outside of a detailed report. We now have standing committees in the field of Cancer Control, Geriatrics, Infantile Paralysis, Infectious Diarrhea, Maternal Health, Rheumatic Fever Control, Tuberculosis Control, Venereal Disease Control, Diabetes Control and others. Several of these perform an advisory function for state or national agencies. It is worth noting that the experimental work in some of these fields has developed medical control patterns attracting national attention. The Society now employs a full time co-ordinator for Rheumatic Fever Control. Pioneer work in cancer detection holds promise of vastly improved medical co-operative technique in the future, probably along the lines of the Hillsdale Plan.

Some of the hardest work of the year has developed upon the Committees for Mental Hygiene, Postgraduate Education, Preventive Medicine and Industrial Health. There has been an increasing demand for spadework in these areas. We hope that from the efforts of the Mental Hygiene group will come a working guide and outline on the subject for the use of the General Practitioner. Medical progress is rapidly approaching a stage where every scientific advance must be matched with a corresponding advance in co-operative work, and educational and distribution technique, if it is to be generally available.

Our work during the past year, for better or for worse, has been devoted toward achieving this goal.

I have purposely reserved until last a comment on the work of the Commission on the Healing Arts. This group has patiently investigated the complex and extremely controversial problems inherent in the widespread practice of Osteopathy in some areas of this state. You will soon have an opportunity to consider these problems yourself in equal detail. But I would like to refer the matter to you accompanied by three personal observations. First, as members of a public service profession, we must necessarily regard with tolerance the views of all practitioners of healing arts who reasonably attempt to employ sound scientific methods in combating human pathology. Second, any study of this problem must be regarded as merely exploratory, since final solution is probably impossible until our state possesses a single workable Medical Practice Act. And third, it is quite possible that revised and improved standards in the various osteopathic schools may soon remove most of the controversy from the issue.

THE SPEAKER: The President's Address will be referred to the Reference Committee on Officers' Reports.

It is now my pleasure to present to you the President-Elect, C. E. Umphrey, M.D.

IV. President-elect's Address

By C. E. Umphrey, M.D., Detroit

What is going to happen in the coming year? In the absence of a seer or prophet among us I would like to propose that we pool our ideas and concentrate our efforts on those problems which seem most imminent.

We are already rapidly applying ourselves to the overall planning of civil defense. We must assemble all the scientific information available concerning atomic power, radiation, bacteriological and chemical warfare. We must know the better methods of treatment. Every Doctor must have this information. He must fit in a preconceived plan. We feel the medical profession is responsible for both lay and professional education in all matters concerning medical care. The Michigan State Medical Society has a scientific committee (Committee on Atomic and Allied Procedures) whose function it is to accumulate these scientific facts. Another committee (National Emergency Medical Service Committee) will integrate our work with all the lay units. Watch for their special releases. Also digest carefully the space devoted to this subject in the MICHIGAN STATE MEDICAL SOCIETY JOURNAL and the Secretary's letters. Encourage all county medical societies to hold meetings on disaster planning if they have not already done so. In order that the central office may know how rapidly this project is being completed such meetings should be reported at once.

Have we gained or lost in our struggle to stem Socialism? There is evidence that we have lost. "Bit-

by-bit" legislation has continued to dismantel freedom and concentrate the individual's rights under bureaucratic power emanating from Washington. This then would continue to be our problem number one.

Is our "Good Citizen Campaign" the best approach? If Pennsylvania and Florida men of medicine could so awaken their citizens to the perils of socialism, we also should be capable of selecting honest fearless government leaders in Michigan. I believe our plan is a good one. That it has not worked to its fullest capacity is a problem that each of us must solve in our own communities. This or any other plan is not going to succeed unless our membership is willing to dedicate their greatest efforts and loyalty to a crusade. Two years ago we made the statement that social activities and even scientific work should be curtailed to a minimum until the American freedom we fought for in 1776, 1917, and 1941 has been unquestionably preserved for future generations. Certainly this project will fail if the American people have been transformed from doers to sitters with hands outstretched for security, to the great white father. Lethargy and apathy can vanish under a campaign such as ours.

I can only entreat you delegates who have designated your willingness to serve, by gathering here today, to redouble your efforts and to urge your confreres to do likewise. It has been said in the past that all projects in medicine are conceived and implemented by not over 10 per cent of the profession. Your officers have dedicated their services to the projects of your bidding. If we are to succeed, we must have your advice and immediate co-operation.

We believe we have a superabundance of talent. We shall try to distribute that talent on committee work, so that each project shall receive the consideration due it without becoming an undue hardship. It was with this in mind that the Secretary's letter carried a request to recommend committee personnel. Although this work has been nearly completed, your suggestions are still solicited.

What then should be project number two? It doesn't much matter whether it is insurance, cancer, rheumatic fever, allied professions, postgraduate clinical conference, immunization, radio, cinema, health council, public relations in general, rural medical care, veterans care, use and mis-use of atomic power, or World War III. If our American freedoms lose to the socialists, communists, do-gooders, and national planners, then apathy and lethargy will have won its full share of grief and retardation for millions of our citizens. Support of Michigan's twenty-seven medical "firsts," and completing new projects for better living is only feasible if we successfully sustain project number one.

In the past we have enjoyed working for our confreres. As we follow in the footsteps of our many eminent predecessors in Michigan, it is only human to miss their wise counsel. It is also human to be just a little envious, because we believe they were never confronted with as many grave situations. Because of the gravity of the situations and the brevity of time, the officers of the Michigan State Medical Society wish to make doubly sure that none of our membership talent is overlooked. We have reached a point where we cannot look to the officials to take on added duties. They are at a saturation point. To ask more service from one is already devoting a minimum of 30 days each year, to our cause would seem like an imposition.

Our attitude toward the medical profession is as it has always been. It is the best organization one could possibly belong to. We are, however, subject to the same complacent lack of interest in the vital events occurring today as are all other American citizens. It is our duty to create such a state of awareness, that those who vote will select men and women of integrity to represent us in all departments of government. To this end, I pledge you my best efforts. Will the other members of the medical profession join me in a pledge to preserve American principles of freedom at all costs? It is better to give our all now, than to look back as slaves and wish we had!

THE SPEAKER: This Address will be referred to the Reference Committee on Officers' Reports.

The next item of business is the annual report of The Council, to be given by O. O. Beck, M.D., Chairman.

V. Annual Reports of The Council

SUPPLEMENTAL REPORT OF THE COUNCIL

1. *Membership*—As of September 11, 1950, the membership of the Michigan State Medical Society totaled 5,029 including 367 Special Members who are relieved from paying dues and assessments.

2. *Finances*—The Constitution of the Michigan State Medical Society charges The Council with administration of the funds of the Society, and the Treasurer with the responsibility for safe keeping of the Society's invested funds.

Following the mandate of the Constitution, The Council has caused an "annual audit to be made of the funds of the Society by a certified public accountant." The complete report of Ernst and Ernst, for the year 1949, was published in the March, 1950, issue of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY beginning at Page 358. On Page 361 of the same number of THE JOURNAL is a copy of the MSMS budgets for the year 1950. The audit of Ernst and Ernst is and always has been available for inspection by any member of the Michigan State Medical Society who may call at the Executive Offices, 2020 Olds Tower, Lansing 8.

The report of our auditor for the first eight months of this year (from January 1 to September 1, 1950) of income and expense is as follows:

Account	On Hand 1/1/50	Income to 9/1/50	Expenses to 9/1/50	Balance on Hand 9/1/50
General Fund	$ 57,803.59	$ 73,131.31	$ 52,537.72	$ 78,397.18
Annual Session	— 0 —	17,952.00	3,972.93	13,979.07
P.G. Institute (1950)	— 0 —	9,000.00	8,782.49	217.51
THE JOURNAL	— 0 —	38,469.26	30,854.56	7,614.70
Public Education—Current	35,238.62	94,898.75	40,055.92	90,081.45
Public Education—Reserve	33,254.46	— 0 —	31,755.73	1,498.73
Rheumatic Fever	28,887.97	8,061.58	13,009.98	23,939.57
TOTALS	$155,184.64	$241,512.90	$180,969.33	$215,728.21

Estimated Over-All Budget for 1951

Estimated Income			
1951 Dues (4,400 members at $37.00)		$162,800.00	
Allocated $15.50 to General Fund	$ 68,200.00		
Allocated $1.50 to THE JOURNAL	6,600.00		
Allocated $20.00 to Public Education	88,000.00		
Estimated Balance 1/1/51, Public Education		55,727.00	
Estimated Balance 1/1/51, General Fund		57,803.00	
Advertising Sales, Reprints and Cuts		50,000.00	
Annual Session 1951		20,000.00	
Postgraduate Clinical Institute		9,000.00	
Rheumatic Fever Program ($15,000) plus cash on hand ($17,000)		32,000.00	
Interest and Miscellaneous Income		100.00	$387,430.00
Estimate Expenses:			
Administrative and General Expense		$ 36,100.00	
Society Expense		17,700.00	
Committee Expense (incl. Mich. Health Council)		25,000.00	
Public Education Expense		140,800.00	
JOURNAL Expense		52,900.00	
Annual Session Expense		20,000.00	
Postgraduate Clinical Institute Expense		9,000.00	
Rheumatic Fever Expense		20,000.00	
Contingencies and Surplus (incl. earmarked Rh. Fever Fund)		65,930.00	
			$387,430.00

More detailed financial reports from January 1, 1950 to September 1, 1950, and also on the "Bond Account" as reported by the Treasurer to The Council at its meeting of July 16-18, 1950, have been presented today (in mimeographed form) to all members of the House of Delegates.

3. *Public Education Account*—A special $25.00 assessment was levied by the 1949 MSMS House of Delegates in order to secure "additional funds for various purposes in the work of the Michigan State Medical Society" (quoting the House of Delegates Resolution). The accumulated funds were used in 1950 for two purposes: (a) $5.00 per capita to bolster the General Fund of the Society which has ended the years 1948 and 1949 in the red; the present low dues of $12.00 per capita have proven totally inadequate to carry on the greatly increased work of your State Society with its accompanying expense; (b) $20.00 per capita was devoted to public relations and public education purposes, as indicated in the following accounting for the first eight months of 1950:

PUBLIC EDUCATION

Income on Hand 1/1/50:	$ 35,238.62	
Assessment of Members	92,595.00	
Assessment of Members—Prior Years	406.25	
Income from sale of Movie (To Your Health)	1,897.50	
TOTAL:		$130,137.37
Expenses:		
Clipping Service	$ 170.38	
Committee Meeting Expense	1,264.01	
Equipment and Repairs	59.99	
Postage	206.91	
Printing, Stationery & Supplies	718.63	
Office Rent and Light	572.24	
Salaries	11,786.32	
Telephone & Telegraph	1,169.20	
Travel Expense	1,310.02	
Misc. General Expense	1,557.13	
Cinema	1,149.77	
Newspaper Advertising	401.11	
Publications & Pamphlets	341.25	
Radio—"Tell Me, Doctor" programs	15,802.30	
National Meeting Expense	914.61	
Annual County Secretary's—Public Relations Conference	2,632.05	
TOTALS:	$ 40,055.92	40,055.92
Balance on Hand 9/1/50		$ 90,081.45

4. *Public Education RESERVE Account*—On January 1, 1950, the reserve for contingencies amounted to $33,254.46. This was the balance from the $100,000 placed at the disposal of the Special Committee on Education on January 1, 1949, to fight the imminent threat of political medicine—the emergency for which we had been building a reserve fund. The members of the Special Committee on Education (L. W. Hull, M.D., Chairman, O. O. Beck, M.D., L. Fernald Foster, M.D., E. A. Osius, M.D., and C. E. Umphrey, M.D.) reports the following expenditures from January 1, 1950 to September 1, 1950, in the Michigan CAP and Good Citizenship Campaign against statism and collectivism. The Committee feels that the present concentrated activity and unified force of the Michigan medical profession more than justifies the labor and expense of maintaining these two effective campaigns.

PUBLIC EDUCATION RESERVE

Income on Hand 1/1/50:		$ 33,254.46
Expenses:		
Salaries	$ 14,867.73	
Printing, Stationery & Supplies	9,029.22	
Postage	355.80	
Telephone & Telegraph	1,588.64	
Travel	3,615.75	
Office Equipment	15.45	
Publications & Pamphlets	111.63	
Meeting Expenses: Special Committee	411.27	
on Education Field Secretaries	4.00	
Other Meetings	1,168.35	
May 7, 1950 CAP Meeting	554.38	
Miscellaneous Expense	33.51	
TOTALS	$ 31,755.73	$ 31,755.73
Balance on Hand 9/1/50:		$ 1,498.73

After two years' expenditure (1949 and 1950), it is anticipated that the Public Relations RESERVE Account will be depleted, as originally planned. However, it is hoped that on December 31 of this year, a surplus of approximately $50,000 will remain in the Public Education Account despite a year of maximum activity.

5. *Estimated Public Relations Budget for 1951.* The Public Relations Committee recommends that the Public Education Account and the Public Education RESERVE Account be amalgamated for the year 1951, and presents the following estimate for its public education expenditures for the year 1951:

ESTIMATED BUDGET FOR PUBLIC EDUCATION
(Based on $20.00 per capita of the assessment or dues)

	1951 Budget
Cash on Hand	$ 55,726.90
Income from P. E. Assessment	88,000.00
Total Funds Available (P.E.)	$143,726.90
EXPENSES:	
Clipping Service	$ 300.00
Committee Meetings	2,000.00
Equipment and Repairs	300.00
Postage and Mailing	3,500.00
Printing	600.00
Stationery and Supplies	1,100.00
Office Rent and Light	900.00
Salaries	43,000.00
Telephone and Telegraph	4,400.00
Travel	7,200.00
Cinema	5,000.00
Display Advertising	500.00
Newspapers	2,500.00
Publications and Pamphlets	8,000.00
Radio "Tell Me, Doctor"	23,000.00
School—Sex Education	— 0 —
National Meeting Expense	1,500.00
Co. Secretary's and PR Conference	3,000.00
Miscellaneous General Expense	2,500.00
Special Committee on Education	500.00
Rural Health Conference	— 0 —
County Society Meetings	1,000.00
Field Secretary's Meetings	— 0 —
P.E. Sinking Fund	30,000.00
Total	$140,800.00
Estimated Balance on Hand January 1, 1952	$ 2,926.90

From the above financial data it is obvious that a continuation of maximum income to carry on the Society's work in 1951 is necessary, as the threat from socialization is still very much with us; in addition, the need for reserves in anticipation of less MSMS dues paying members during wartime is obvious.

A recommendation on this subject follows.

6. *Mediation Committee*—As part of its public relations activity, the Michigan State Medical Society has a Mediation Committee which acts as an appeal board for the prompt adjudication of breaches of medical professional relations that continually plague the best public relations efforts of medical societies.

According to reports received by the State Society Executive Office, 26 county medical societies of Michigan have appointed mediation committees, in accordance with the recommendation of The Council and the House of Delegates in September, 1949.

The Council again urges the House of Delegates to use its influence to the end that every county medical society appoints a mediation committee for the prompt settlement of "dispractices," which may not be sufficiently severe to receive the attention of the Ethics Committee but which seriously hamper the good public relations of Medicine.

A recommendation on this subject follows:

7. *Michigan Medical Service.* An up-to-date report on this Corporation, including finances and the $5,000 income limit proposal, will be presented to you at the meeting of Michigan Medical Service membership tomorrow, September 19, at 2:00 p.m. in the Grand Ballroom, Book-Cadillac Hotel. All MSMS Delegates are members of the Michigan Medical Service Corporation and are expected to attend this important Annual Meeting.

8. *The majority report and three minority reports of*

the Commission on Healing Arts. The MSMS House of Delegates, on September 20, 1949, adopted a motion that The Council be ordered to appoint a commission to study the osteopathic problem, and report back at the next annual session of the House of Delegates. The Council appointed this group, known as the "Commission on Healing Arts" which recently presented its reports to The Council. These reports are respectfully referred to the House of Delegates for consideration on this date, in executive session.

9. *County Hospital Staff Membership (Grand View Hospital at Ironwood):* The Michigan Attorney General recently rendered two opinions: (a) that osteopaths and (b) chiropractors have a legal right, under the County Hospital Act, to practice in hospitals organized under the provisions of Act 350 of the Public Acts of 1913. These opinions have been the subject of much serious discussion at recent meetings of The Council and of its Executive Committee. The consensus is (a) that the opinions are in error, (b) that some judicial determination probably is necessary to gain a definite decision, and (c) that this is more a hospital than a medical problem.

10. *Procurement and Assignment, 1950.* At the suggestion of the American Medical Association. The Council of the Michigan State Medical Society nominated G. C. Penberthy, M.D., of Detroit as Chairman of Procurement and Assignment for the State of Michigan. Two Vice Chairmen also were appointed, H. H. Stryker, M.D., of Kalamazoo and John R. Rodger, M.D., of Bellaire. The Council recommended to the AMA that the Procurement and Assignment files be made in triplicate and housed in three different areas of the State (wherein the Chairman and two Vice Chairmen of Procurement and Assignment reside) in order to prevent their loss in case of atomic or other major disaster to any one area.

The American Medical Association, on August 12, 1950, voted its definite endorsement of the principle of several bills pending in Congress in August which provided for the registration and induction into service of certain technical and specialists personnel, including doctors of medicine. This endorsement was reiterated by the MSMS Committee on Emergency Medical Service (on August 23, 1950).

The new doctor-draft law provides for the establishment of a National Advisory Committee "which shall advise the Selective Service system and co-ordinate the work of state and local volunteer advisory committees with respect to the retention***" professional personnel. The law does not require state or local committees to be established. Inasmuch as actual deferment is at the discretion of local selective service boards, local advisory committees under guidance of the National Advisory Committee may eventually become useful to the profession and the public.

11. *Atomic Energy.* The MSMS Committee on Atomic and Allied Procedures recently was created to study and report to the profession (a) on medical uses of atomic energy; (b) industrial uses and hazards of atomic energy; and (c) medical and technical defense in modern scientific warfare. This Committee, together with the MSMS Emergency Medical Service Committee (the two state society committees tied in with the present war effort) strongly recommend that county medical societies of Michigan arrange several programs which teach evacuation and disaster techniques and medical-industrial uses of atomic energy through films and with narrative presented by a member of one of these two MSMS Committees. It is to be noted that two talks on atomic energy are included in the program of the 1950 MSMS Annual Session.

A recommendation on this subject follows.

12. Two additional important subjects are still under discussion:

(a) *Admission Policy at University of Michigan Hospital* (in-patient). When this Study is completed, further information will be sent to all MSMS members through the Secretary's Letter.

(b) *Study of Medical Practice Act.* During the past year, a special MSMS Committee has been working jointly with a Committee of the State Board of Registration in Medicine on this project. The Joint Committee hopes to propose to the 1951 Michigan Legislature certain amendments to modernize the Michigan Medical Practice Act of 1899.

Recommendations

We respectfully invite to your attention the six recommendations in the original report of The Council printed in the Handbook on Pages 43-60. They read as follows:

The Council recommends:

1. That each and every member of the MSMS continue to co-operate wholeheartedly, both by individual action and financially, to aid the AMA and its National Education Campaign in a program of active and direct resistance against any attempt to throw the practice of medicine into politics. The past loyalty of Michigan's medical men toward the AMA is highly commended. Michigan stands in the forefront of those states whose voluntary help to our parent organization is near the 100 per cent mark.

2. That representatives of the MSMS be instructed to continue their yearly visit to Washington, D. C., on the occasion of Michigan Day sponsored by the U. S. Chamber of Commerce.

3. That newspaper and magazine editors and feature writers who have and are publishing splendid articles, factual news stories and strong editorials against socialism, be sent official letters of commendation.

4. That the By-Laws be changed so that the word "Consecutive" in the section on Life Membership (Chapter 5, Section 7) is deleted.

5. That the MSMS co-operate in a national conference on state and community health leadership, proposed for Detroit on October 1, 1950, under the sponsorship of the AMA and the MSMS.

The sixth recommendation originally read:

"That the Annual Dues of the Michigan State Medical Society be increased sufficiently to provide necessary appropriations to the MSMS General Fund and for the various purposes in the work of the Michigan State Medical Society."

The Council, at its meeting of September 17, 1950, amended the recommendation to read as follows:

6. That the annual dues of the Michigan State Medical Society be set at $50.00 to provide necessary appropriations for the various purposes in the work of the Michigan State Medical Society.

The Council respectfully submits two additional recommendations:

7. That the House of Delegates as a whole and each Delegate as an individual use all efforts to the end that every county medical society in Michigan has an active Mediation Committee so that any complainant may be apprised of the fact that there is available in every county medical society a Mediation Committee to which the complainant may make reference in writing, in case of alleged "dispractice."

8. That county medical societies give priority to programs, during the ensuing months, which teach evacuation and disaster techniques and which explain the medical-industrial uses of atomic energy, in the preparation of which programs the assistance of the MSMS Emergency Medical Service Committee and the MSMS Committee on Atomic and Allied Procedures is offered.

Respectfully submitted,

O. O. Beck, M.D., *Chairman*
R. J. Hubbell, M.D., *Vice Chairman*
L. W. Hull, M.D.
P. A. Riley, M.D.,
Wilfrid Haughey, M.D.
J. D. Miller, M.D.
R. C. Pochert, M.D.
H. B. Zemmer, M.D.

L. C. HARVIE, M.D.
E. A. OAKES, M.D.
F. H. DRUMMOND, M.D.
C. A. PAUKSTIS, M.D.
A. H. MILLER, M.D.
W. S. JONES, M.D.
J. S. DeTAR, M.D.
E. A. OSIUS, M.D.
W. B. HARM, M.D.
WILLIAM BROMME, M.D.
R. H. BAKER, M.D., *Speaker*
W. E. BARSTOW, M.D., *President*
C. E. UMPHREY, *President-Elect*
L. FERNALD FOSTER, M.D., *Secretary*
A. S. BRUNK, M.D., *Treasurer*
E. F. SLADEK, M.D., *Immediate Past President*

THE SPEAKER: This report will be referred to the Reference Committee on Reports of The Council.

EXECUTIVE SESSION

E. D. SPAULDING, M.D. (Wayne): I move that we go into Executive Session.

R. A. SPRINGER, M.D. (St. Joseph): I second it.

THE SPEAKER: Is there any comment? If not, are you ready for a vote on the motion that we go into Executive Session? All those in favor of the motion say, "aye"; opposed, "no." The motion is carried.

* * *

I now declare The House in Executive Session. I call on J. S. DeTar, M.D., at this time.

VI. Report of Commission on Healing Arts (in Executive Session)

J. S. DeTar, M.D., Milan, presented the prepared report of the Commission on Healing Arts.

The meeting was recessed at 1:00 p.m.

MONDAY AFTERNOON SESSION

September 18, 1950

The House of Delegates reconvened at 2:10 p.m.

VIII. Report of Delegates to AMA

AMA Interim Session, Washington, D. C. December 6-9, 1949

After the call to order, the first order of business was the election of the General Practitioner of the year. Dr. Andy Hall of Mount Vernon, Illinois, a graduate of Northwestern Medical School in 1890, and who had practiced in Mount Vernon, Illinois, for nearly sixty years and who had served in three wars, the Spanish-American, the Philippine insurrection in 1900, and World War I, was elected over Dr. Lyle "Bunny" Hare, Spearfish, South Dakota, and Dr. Thomas Edwin Rhine of Thornton, Arkansas.

The Address of the Speaker, and the appointment of Reference Committees, which included, Dr. Jan Paul Pratt, Section of Obstetrics and Gynecology, Grover C. Penberthy, Section on Surgery, Wyman D. Barrett and Willis H. Huron from our State Society were included. Then followed the Address of the President, Dr. Ernest E. Irons, who pointed out to us the dangers that confront the medical profession and the citizens of our country in the present trend in Government towards the Welfare State and reviewed our fight over the past year against these socialistic trends. He also called attention to the coming months of our battle and expressed confidence that we would continue to combat these trends, only if the medical profession, individually and through our various state and component county societies would continue to be enthusiastically alert.

President-elect Elmer L. Henderson was then presented to The House, and made no comment.

Report of the Officers: Dr. George F. Lull, Secretary, reported that the membership of 143,000 was the largest in the history of the American Medical Association.

Report of the Board of Trustees, by Dr. Louis Bauer, on a proposed amendment to the By-Laws: Amendment to the By-Laws, Division One, Chapter II, page 9. Tenure and Obligations of Membership. Dues.

Section 1. When the Secretary is officially informed that a member is not in good standing in his component society, he shall remove the name of said member from the membership roll. A member shall hold his membership through the constituent association in the jurisdiction of which he practices. Should he remove his to another jurisdiction, he shall apply for membership through the constituent association in the jurisdiction to which he has moved his practice. Unless he has transferred his membership within six months after such change of practice, the Secretary shall remove his name from the roster of members.

Section 2. Annual dues, not to exceed $25.00, may be prescribed for the ensuing calendar year in an amount recommended by the Board of Trustees and approved by the House of Delegates. Each active member shall pay said annual dues to his constituent association for transmittal to the Secretary of the American Medical Association.

An active member who is delinquent in the payment of such dues for one year shall forfeit his active membership if he fails to pay the delinquent dues within thirty days after notice of his delinquency has been mailed by the Secretary to his last known address.

This was the recommendation of a special committee appointed, by The House to be given to all state society secretaries to be utilized as the state societies see fit.

Also pointed out comments on Senate Bill 1453, concerning Federal Grants to Medical and other Health Professional Schools.

Criticism offered by the Council on Education and Hospitals, clearly indicates that this bill is not satisfactory and that it is potentially dangerous to the continued academic freedom of the Medical Schools and that the Board of Trustees feels that since this bill does not guarantee such freedoms and since the bill contains other undesirable features, that it must offer opposition to the enactment of this bill.

ETHICS.—The attention of The House is called to the fact that some state associations have set up special machinery for taking disciplinary action on their members for overcharging and for other violations of the Principles of Medical Ethics. The Board recommends that all of the states whose societies have not done this study the situation with a view to establishing some form of grievance committee to control such matters.

RETIREMENT OF DR. MORRIS FISHBEIN.—The Board of Trustees announces that Dr. Morris Fishbein, by mutual agreement, was retired as Editor of *The Journal of the American Medical Association* on December 1, 1949. The Board has made arrangements for adequate lifetime remuneration for Dr. Fishbein.

Dr. Fishbein has given thirty-seven years of devoted service to the American Medical Association. He has been the worthy successor to Dr. George H. Simmons, who laid the foundation for the present high standing of *The Journal of the American Medical Association*. The fact that *The Journal* is now the outstanding medical publication in the world is due to Dr. Fishbein's editorial genius which has been exerted over the past twenty-five years. The American Medical Association

and the entire medical profession owe him a debt of gratitude.

APPOINTMENT OF DR. AUSTIN E. SMITH AS EDITOR.—The Board announces that Dr. Austin E. Smith has been appointed as Editor to take the place of Dr. Fishbein.

CHANGE OF NAME OF *HYGEIA*.—The Board announces that the name of the magazine *Hygeia* has been changed to *Today's Health*. This change was made after a careful study and opinions were received from various individuals who were interested in the magazine, and it was thought to be in the best interest of all concerned to make this change.

WORLD HEALTH ORGANIZATION.—The Board also urged all members of the American Medical Association to join the World Medical Association, saying that they were anxious to have at least 5,000 members of the American Medical Association as members of the United States Committee so that the aims and ideals of the World Medical Association can readily be carried out. The United States Committee has guaranteed to underwrite the expenses of the Secretariate, certain expenses of The Council and the publication of *The Bulletin* for a number of years.

* * *

REPORT OF THE JUDICIAL COUNCIL was presented by Dr. E. R. Cuniffe, who reported on the revision of the Principles of Medical Ethics.

REPORT on THE COUNCIL of MEDICAL EDUCATION AND HOSPITALS, who set up essentials of an acceptable school of Physical Therapy and an acceptable school for Record Librarians.

REPORT of THE COUNCIL on MEDICAL SERVICE, concerning lay-sponsored voluntary health plans.

Following the conclusion of the report of the officers, resolutions were introduced on establishment of annual dues for active membership, by Dr. James C. Sargent, of Wisconsin. Since you are familiar with this, and have been informed by the Secretary of the Association, no further comment is offered.

RESOLUTION on MEDICAL and HOSPITAL CARE OF VETERANS with NON-SERVICE CONNECTED DISABILITY was offered by Dr. Robert B. Wood, of Tennessee, on behalf of the delegations from the states of Tennessee and Texas. This was the most controversial of all resolutions presented, and since Dr. Wyman D. Barrett of our delegation was a member of the Reference Committee that considered the resolution, he can give all of the facts. However, the report of the committee was rejected by the House, and the Speaker was directed to appoint a committee from the members of the House of Delegates to report next year with definite recommendation as to what The House stands for on this issue. This was carried.

RESOLUTION on FORMATION of JUNIOR AMERICAN MEDICAL ASSOCIATION, consisting of medical students and interns, to affiliate with the national organization, was passed.

RESOLUTION on COMPENSATION for TRUSTEES AND GENERAL OFFICERS was passed, with reservations.

RESOLUTION ON SPECIALTY TRAINING, setting up two or three years of general practice before specialization was undertaken, was offered by three states.

RESOLUTION on GENERAL PRACTICE SECTIONS IN HOSPITALS, asking that the House of Delegates again re-affirm its actions of December, 1946, and June, 1949, concerning general practice in hospitals, was again adopted.

Many more resolutions concerning voluntary Health Insurance Plans, were all considered and adopted. Dr. R. L. Novy attended most of these Reference Committee meetings and is better informed to report than other members of our delegation.

RESOLUTION on an appointment of a committee of non-medical men to assist in the American Medical Association campaign was unanimously adopted.

RESOLUTION on remission of dues, by Dr. John W. Cline, of California: RESOLVED, That the House of Delegates request the Board of Trustees to ask the state and county societies to remit dues payable to the American Medical Association on the same basis that they would remit dues payable to themselves.

The motion to adopt was regularly seconded and discussed, after which Dr. Cline deleted the words "state" and "after" the, and left in "county medical societies."

After further discussion, Dr. G. Henry Mundt, Illinois, made a substitute motion that the Board of Trustees study the problem on a national basis and proceed with its findings in the matter of the collection of the dues, and the substitute motion was carried. Dr. Mundt was asked to repeat his substitute motion, which was done for him by the reporter.

Dr. Howard Schriver, Ohio, moved to reconsider the vote so that the Board be informed that there shall be no exclusion from the payment of dues of any member in the active practice of medicine. Dr. E. Vincent Askey, California, stated that the original motion was still before the House as amended and that Dr. Schriver's motion was an amendment; Dr. G. Grady Dixon, North Carolina, requested another amendment, that no member be relieved from the payment of dues to the American Medical Association, regardless of state and county, without special action of the Board of Trustees, which was not seconded. Dr. Schriver was asked to restate his amendment which he did as follows:

The amendment was offered, that all members of the medical profession in active practice in the United States in order to maintain membership in the American Medical Association, and that the question of non-payment of these dues in exceptional circumstances be left to the discretion of the Board of Trustees. The amendment was seconded by Dr. G. Grady Dixon, North Carolina.

After further discussion, Dr. Cline's resolution, as amended, was adopted.

All members of the Michigan delegation attended all sessions of the House. Dr. Ralph A. Johnson, alternate delegate, was in attendance at all sessions and attended and entered into the deliberations of several of the reference committees. The members of the delegation who were not serving on reference committees attended as many of the hearings before reference committees as was possible. All of the Michigan delegation, along with several of the State Officers including the President and President-Elect, Mr. Brenneman, Dr. Candler, the Secretary of the Wayne County Medical Society, and the President of the American Academy of General Practice, met with the members of the delegations from other states for breakfast in the Michigan Room. It was here where we exchanged ideas and formulated plans for future meetings in order that we might have support in carrying out the ideas and ideals of The House of Delegates and The Council of the Michigan State Medical Society.

AMA House of Delegates, San Francisco, June, 1950

Ten thousand doctors attended the 99th Annual Meeting of the American Medical Association in San Francisco.

The House of Delegates, made up of 198 delegates, was in session from Monday through Thursday and transacted a great volume of business. On one day alone action was taken on seventy-four different items.

In spite of the multiplicity of items, there was a certain unity, for various problems by constantly recurring became preponderant and that basic policies underlying these problems varied little. Dr. Henderson of Chicago, President, keynoted the meeting in his address:

"We have accomplished a great deal but the fight is not ended and we must continue to fight for freedom of American people and freedom of medicine and the defeat of socialism."

There were two general phases in the fight for freedom of medicine: The predominant one, the fight against federal control of medicine; the other, the fight against subjugation and encroachment by groups within the medical profession, primarily the specialty boards and hospitals.

In the fight against federal control, the House of Delegates mainly reaffirmed previous action, summarized under the following headings: "The National Education Campaign," "Public Relations" and "Legislation."

National Education Campaign

Expressed its approval of the campaign as conducted during the past 18 months. In his speech Dr. Irons, retiring president, summarized some of the results. "Two years ago we were on the defensive. Citizens now understand better the threat of socialism and we are on the offensive. Much of the inertia has been overcome." He stated that 10,000 organizations already have adopted resolutions opposing compulsory health insurance. The campaign for voluntary insurance has resulted in 68 million persons obtaining hospital protection, 40 million against surgical costs and 16,000 are being added daily to voluntary health insurance plans. It was also reported that since the start of 1949 more than 77 million pamphlets, folders and leaflets have been distributed.

Approval of the renewal by the Board of Trustees of its contract with Whitaker and Baxter for another year.

Approved the projected program of Whitaker for a nationwide advertising campaign in October through newspapers, radio and magazines. The cost of this program will be approximately one million dollars.

Public Relations

The officers in their addresses to the House emphasized the importance of physicians as citizens and their responsibility to vote.

The House of Delegates recommended that the Public Relations Department of the AMA and the Washington Office be expanded.

Recommended that each County Society provide a Grievance Committee, telephone emergency service, information service and provide information as to medical care for the indigent.

Legislation

The House of Delegates opposed the following bills:

S-1453—FEDERAL AID TO MEDICAL EDUCATION and stated "We will oppose any bill for federal subsidy of medical schools until federal control of our medical schools is impossible."

S-1411—SCHOOL HEALTH SERVICE ACT.

S-522—LOCAL PUBLIC HEALTH UNITS.

For clarification it was stated that Public Health should not be for diagnosis of disease and should not undertake any treatment except for indigent, venereal disease and tuberculosis and non-indigent only if treatment is not available through private sources.

REORGANIZATION PLAN No. 27.

Requested the Legislative Committee to review the question of income tax exemption for postgraduate training with the end in view of introducing legislation if deemed advisable.

Attention was called to the Supreme Court ruling in 1942 which gives the government power to regulate that which it subsidizes. It was also emphasized that no emergency exists regarding health and medical care in this county and that any legislation to meet health needs would be premature until the present health survey has been completed and facts made available.

Hospitals and the Practice of Medicine

The fight against subjugation of medicine by groups within the profession centered on the relationship of physicians with hospitals and the specialty boards. (Action taken by the Delegates relative to specialty boards is under the heading "Medical Education.")

Action on the physicians' relationship with hospitals was centered on the Hess Report which had been discussed by the House at the two preceding sessions. At the current session resolutions in support of this report were introduced by five different states. After a long discussion an amended version of this report was passed by the House of Delegates. Some of the basic principles stated in this report are:

1. Physicians in their relationships with hospitals must be guided by the Principles of Medical Ethics of the AMA as stated in Chapter 1, Section 3; Chapter III, Article VI, Sections 2, 3, and 6.
2. In almost all instances it is illegal for a corporation to hire a professional man and then sell his services to the public on fee basis for the profit of the corporation.
3. That a physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual by whatever name called, or however organized, under terms or conditions which permit sale of his services by this agency for a fee.
4. Where hospitals are not selling services of a physician financial arrangements may be placed on a mutually satisfactory basis. For teaching, research, and charitable purposes corporations may provide such services and engage doctors.
5. It is the opinion of the AMA that the practice of anesthesiology, pathology, physical therapy and radiology are an integral part of the practice of medicine in the same category as surgery or internal medicine.

To carry out these principles it was recommended that:

1. Blue Shield and Blue Cross be requested to cooperate to the extent of writing all new contracts in such a manner that Blue Shield will cover insurable medical services and Blue Cross will cover insurable hospital services.
2. In the event of a controversy between physicians or between physicians and hospital management that every effort be made to settle it at the staff management level; if it cannot be solved then assistance of the County Medical Society should be requested; next the State Medical Association; finally, it can be referred to the Judicial Council of the AMA.
3. Each County Medical Society appoint a Committee on Hospital and Professional Relations.
4. If and when a physician is found to be unethical by the proper authorities and is still retained by a hospital approved for intern and resident training, the Judicial Council may request the Council on Medical Education and Hospitals to show cause why the Council should not remove such a hospital from the approved list.

Medical Education

The House of Delegates took the following action in the field of Medical Education:

(a) Residency Training:

Approved the revision of essentials for approved internships and residencies. Appointed a committee to study the problem of two-year rotating internship and the extension of the requirements for residencies in obstetrics and gynecology.

Reaffirmed the principle of uniform inspection between the specialty boards and the AMA.

For clarification stated, "It should not be essential or even desirable that all hospital residencies should adopt same program or experience but it is essential that all hospitals should meet requirements of approved hos-

pitals and obtain comprehensive results." Disapproved the practice of certain hospitals that make specialty rating a requirement for appointment and promotion. Further stated, "The particular specialty in which residents are being trained should be represented on hospital staff by well-qualified specialists whether or not they hold Specialty Boards." Urged the Council on Medical Education and Advisory Committee to Medical Specialty Boards to exercise the greatest discretion in approving new Specialty Boards.

(b) Organization for Interns and Medical Students: Stated that the AMA cannot support the Association of Interns and Medical Students.

Approved the proposal submitted by the AMA for the establishment of a Student American Medical Association and recommended that if and when such organization is set up that it be given the active support of the medical profession.

(c) General Practice:

1. Approved the report of the Committee on General Practice which recommends a one year rotating internship followed by one year general practice residency.

That the Specialty Boards give reasonable credit for time spent in general practice.

Continuance of the integration of general practice into hospital staffs. That there be more emphasis on general practice in undergraduate years.

2. Recommended that Academy of General Practice prepare a manual on general practice departments in hospitals.

Membership

The House took the following action regarding membership:

Set the 1951 AMA dues at $25.00.

Amended the By-Laws so that as of January 1, 1951, the dues will include a subscription to *The Journal of the American Medical Association.*

Amended the By-Laws so that Associate Members shall be privileged to attend scientific meetings without the right to vote or hold office.

Urged State and County Medical Societies with restrictive rules to open their doors to Negro doctors.

The Board of Trustees report that:

Fellowship dues for 1951 will be $2.00. Each constituent society will be allowed 1 per cent on AMA dues collected.

National Emergency Service

Urged the immediate passing of adequate federal and state enabling legislation and the immediate establishment, in those states that have not done so, of a civil defense organization headed by a civilian defense director.

That the AMA continue to extend the fullest cooperation with the medical services of the Armed Forces and the National Security Resources Board with the end that the most effective utilization of medical personnel be achieved for the maximum protection of the Nation.

Urged that a Medical Advisory Committee be appointed to function at top level and that the AMA render any and all assistance to it and to the National Security Resource Board as a whole that may lie within its power.

Insurance

Recommended that the service of graduate nurses be included in the prepayment insurance plans.

Urged the evaluation of health insurance policies on a state level.

Approved Committee Reports

The Committee on Blood Banks which included:

(a) Survey of blood banks in the United States. There are in all 1,648 of which 1,571 are hospital blood banks.

(b) The recommendation that the AMA set up minimum regulations for establishment of blood banks.

(c) Emphasized the need for evaluation of nation's blood needs.

(d) Basic principles regarding replacement and interchange of blood.

The Committee on Displaced Persons which urges utilization of these persons in state hospitals and in Indian and Alaskan services. A resolution was also passed recommending that the AMA give moral support to any Medical School or hospital that provides adequate training of displaced persons.

The Committee on Chronic Illness.

Miscellaneous

Postponed action on the resolution regarding medical and hospital care for veterans for non-service connected disability.

Authorized appointment of a Continuing Committee to augment and clarify the AMA 12-point program.

Approved the principle of self testing for diabetes.

Endorsed the World Medical Organization.

Awarded the 1950 Distinguished Service Award to Ernest Graham of St. Louis.

Urged that Congress make adequate appropriation to fight tuberculosis among Indians.

Endorsed the use of all recognized diagnostic procedures for cases of cancer and recommended that in case of mass survey it should be in the hands of qualified private physicians and be conducted on a local level under the State Society.

Approved the surveys of medical care and education in England, which will be published, and urged their dissemination. In his speech, Dr. Irons pointed out that in England there is now insurance to protect against the delay of government medicine.

Election of Officers

President—E. L. Henderson, M.D., Kentucky.
President-Elect—John W. Cline, M.D., California.
Vice President—R. B. Robins, M.D., Arkansas.
Secretary—George F. Lull, M.D., Chicago.
Treasurer—J. J. Moore, M.D., Chicago
Speaker—F. F. Borzell, Philadelphia.
Vice Speaker—James R. Renling, New York.
Trustees—Leonard Larson, North Dakota; Thomas P. Murdock, Connecticut.

Coming Meetings

Interim Session:
1950—Cleveland.

Annual Session:
1951—Atlantic City.
1952—Chicago.
1953—New York City.

Respectfully submitted,
W. H. Huron, M.D.
Wyman D. Barrett, M.D.
Robert L. Novy, M.D.
William A. Hyland, M.D.
L. G. Christian, M.D.

The Speaker: The report as presented by R. L. Novy, M.D., will be referred to the Reference Committee on Officers' Reports.

IX. Report of Committee to Study Councilor Districts

B. R. Corbus, M.D., presented his prepared report.

The House of Delegates, at its last meeting, directed "that a special committee be appointed to study the possible regrouping of counties in Councilor Districts to obtain better representation of the larger societies."

You will remember that delegates from one of the larger counties, stimulated perhaps by the action of the House in adding two new Councilors to the Wayne

County district, advocated, through resolution, that every large county unit should be represented on the Council. The argument of the advocates of the resolution were to the effect that the problems of the district predominantly urban, yet which had within its boundaries counties which were largely agricultural in type, could not be adequately represented by the councilor who happened to come from the outlying district.

The opponents felt that the situation could be well handled locally since in every district wherein there was a large city, predominant control rested within that county by virtue of its larger voting membership.

Your committee felt that this was an excellent opportunity to review the entire state in reference to its Councilor Districts. These were established in 1903, as you know, to correspond with the Congressional Districts. As a first step, the Committee made a comparative study of the present Councilor Districts and the Medical Trading Areas, as developed by Doctor Dickinson of the Bureau of Economics of the AMA. A member of the committee made for us a demonstration with maps, and we find a most striking consistency between the present Councilor Districts and the Medical Trading Areas.

Let me say, as one who was long connected as an executive or official with this organization, that it has ever been the concept of the officers of this Society that there should be a close liaison between its officers and councilors and the members of the Society, to the end that each should be made to feel that he is truly a part of the organization, and should be kept closely in touch with its activities. To that end, councilors have been constantly urged to plan to meet, from time to time, with each County Society within his district, and each is required to report the status of his district at each meeting of the Council. In recent years, the Society has spent thousands of dollars in mailing to each member a Secretary's Letter and innumerable pieces of literature bearing on matters important to you and to your Society.

The phenomenal growth of the Detroit area has been recognized by subdividing the first district. A second councilor was appointed in the 30's, and this area is now represented by four councilors.

The Executive Committee has been increased by two, perhaps three, members since your chairman was first a member of that committee. The addition of the Speaker of the House of Delegates makes for a closer alliance between the committee and the delegates, and the frequent invitations that are extended to members of the Society provide for an open discussion on important matters which can be relayed to the membership.

Your committee is impressed that even at the present time the Council, as an administrative body, is somewhat unwieldly. There is so much business to be transacted in the limited time that can be given to it, that your councilors labor from early morning until late at night. If, as suggested by the resolution, each larger county have a councilor of its own, the present unwieldiness would be made worse, and your committee cannot see that there would be compensating advantage.

Your committee, therefore, recommends that no action be taken that would increase the number of Councilor Districts, nor the number of councilors. Several members of the committee felt that, from the standpoint of efficiency, action might well be taken that would decrease the number of Councilor Districts and the number of councilors.

In the study of the district areas, your committee felt that there were only two changes which might advantageously be made in the arrangement of Councilor Districts.

The first of these two changes would allocate Kalkaska County to the Ninth District from the Tenth District, and the other, to allocate Clinton County to the second District from the Sixth District. It goes without saying that these changes should not be consummated except with the consent of the County Societies concerned. We suggest that the matter be taken up with them.

Your committee feels that this is the proper time to present for your consideration certain suggestions in regard to the election of councilors. It is self-evident that if the councilor is to represent his constituents efficiently and maintain a proper liaison between them and the State Society, he should be one who is held in favor by the men of his district. It is a matter of record that on several occasions the delegates have come into the House without being aware that the term of their councilor had expired. It became necessary, in the midst of the election, for them to make what might well be called a "snap-shot" nomination. Not necessarily was the choice a poor one, but oftentimes the choice did not meet the approval of his constituents, or perhaps there was a feeling on their part that something had been put over.

Therefore, your committee recommends that the Secretary be instructed to notify, well in advance of the annual session, the presidents, the secretaries and delegates of those county societies whose councilor term will regularly expire at that session.

A somewhat similar situation arises when the vacancy in the Council occurs during the session of the House of Delegates. In that event, the committee recommends that opportunity be provided for a caucus of the delegates of the affected district before nominations are made, and suggests that changes in the By-Laws to that effect be made if that procedure is necessary.

Your committee further recommends that except in the above-mentioned situation, provision be made in the By-Laws that delegates be required to submit in writing nominations for councilor at the first meeting of the House of Delegates, and that the election be held as usual at the last meeting of the House.

Respectfully submitted,

BURTON R. CORBUS, M.D., *Chairman*
A. S. BRUNK, M.D.
H. H. CUMMINGS, M.D.
L. J. HIRSCHMAN, M.D.
W. H. HURON, M.D.
C. R. KEYPORT, M.D.
R. S. MORRISH, M.D.
E. F. SLADEK, M.D.
P. R. URMSTON, M.D.

THE SPEAKER: The report will be referred to the Reference Committee on Constitution and By-Laws.

X. Resolutions—Motions and Petitions

X—a. REQUEST FOR REPEAL OF P.A. No. 59 OF 1937.

L. G. CHRISTIAN, M.D. (Ingham): The Ingham County Medical Society unanimously instructed their delegates to present the following resolution:

WHEREAS, the basic science law was enacted by the legislature in 1937 as Public Act No. 59 after many years of study by the Michigan State Medical Society; and

WHEREAS, the original concept was entirely worthy in principle, and it was hoped that it would raise the standard of the healing arts in the State of Michigan; and, however,

WHEREAS, the experience of the past 13 years has demonstrated that the original concept has not been accomplished, but rather the reverse, and in fact the citizens of Michigan have been deprived of the services of many well qualified physicians; and further,

WHEREAS, this has resulted from two particular effects of this law: One, it has discouraged highly trained physicians from undertaking examinations in courses of study in which they qualified years previously; and second, it has discouraged continued study and training in the institutions of this state by young men in view of lack of licensure and the necessity of additional examina-

tions in subjects in which they themselves have already qualified, and thereby imperiled the entire resident training program of the hospitals throughout the state; and

WHEREAS, there have been manifold other objections to the practical application of this law: Therefore be it

RESOLVED, That this House of Delegates goes on record as favoring repeal of the Public Act No. 59 of the regular session of the legislature of the State of Michigan, 1937; and be it

RESOLVED further, That this House instruct The Council and the officers of the Michigan State Medical Society to sponsor through its legislative committee the necessary legislation to accomplish repeal of the above-named act.

THE SPEAKER: This resolution will be referred to the Reference Committee on Legislation and Public Relations.

X—b. URGING DOCTOR OF MEDICINE TO EXERCISE RIGHT OF FRANCHISE

D. R. SMITH, M.D. (Iron Mountain):

WHEREAS the Armed Forces of the United States are once again fighting on foreign soil to preserve the rights of free people; and

WHEREAS, freedom is gained by fighting and retained by voting; and

WHEREAS, an excellent opportunity to reaffirm the faith of Americans in this hard-won freedom becomes available this November 7; Therefore be it

RESOLVED, That the Michigan State Medical Society call upon its members to exercise their right of franchise on November 7, 1950, and to persuade their families, patients and friends to do likewise.

X—c. SUPPORTING UNITED NATIONS.

D. R. SMITH, M.D.:

WHEREAS, the United Nations is conducting a war against Communism in Korea; and

WHEREAS, Socialism is the twin of Communism; and

WHEREAS, the medical profession is strongly opposed to both Socialism and Communism; and

WHEREAS, the medical profession in Michigan has been placing great emphasis upon efforts to combat these pernicious trends; Therefore be it

RESOLVED, That the Michigan State Medical Society reaffirm its determination to halt the socialization of our free economy and pledges its wholehearted support of the United Nations in resisting Communistic aggression in Korea and the full collaboration of doctors of medicine with the Armed Forces of the United States.

THE SPEAKER: These two resolutions will be referred to the Reference Committee on Resolutions.

X—d. URGING INCREASE IN NUMBER OF MEDICAL GRADUATES

P. E. SUTTON, M.D. (Oakland):

WHEREAS, the Michigan State Medical Society's House of Delegates at its 1948 session adopted a resolution "to increase the number of medical graduates," which read:

"WHEREAS, there is a general agreement as to the need for a larger number of physicians; and

"WHEREAS, the facilities for teaching are not sufficiently increased to provide hope in the near future of answering the need for a larger number of physicians; and

"WHEREAS, the number of individuals other than doctors of medicine licensed to practice the healing art in the State of Michigan has increased materially; Therefore be it

"RESOLVED, That the Michigan State Medical Society through its officers support any reasonable means to increase the number of students graduated from medical schools in this state, and that the delegates to the American Medical Association take similar action at the next meeting of the American Medical Association House of Delegates;" and

WHEREAS, the Michigan State Medical Society sponsored and urged the adoption by the 1949 Michigan legislature of a resolution seeking more financial help for the medical schools of the University of Michigan and Wayne University which resolution was instrumental in the action of the Michigan legislature in appropriating funds sufficient to develop plans for an out-patient building connected with the University of Michigan Hospital; and

WHEREAS, the Michigan State Medical Society was prime mover for the calling of the three Michigan Rural Health Conferences (1947-48-49) which stressed:

(a) More facilities to train doctors of medicine;
(b) More facilities in rural areas to attract doctors of medicine; and
(c) Setting up of a loan fund to train doctors of medicine who would agree to practice in rural areas (with the aid of the Michigan Foundation for Medical and Health Education, Inc.); and

WHEREAS, the Michigan State Medical Society, which has supported financially the Michigan Health Council from its very formation, has worked actively with the Council to achieve one of its important projects; i.e., the gaining of the people's support for increased medical education facilities, to secure more practicing doctors of medicine; and

WHEREAS, the Michigan State Medical Society worked successfully with Wayne University to secure from the 1950 Michigan legislature (first extraordinary session) a grant to develop plans for a Medical Science Building at Wayne University College of Medicine; and

WHEREAS, the Michigan State Medical Society used its influence with the 1950 Michigan legislature (first extraordinary session) to obtain a grant for a Medical Center Building for the University of Michigan Medical School, which was appropriated; and

WHEREAS, the Michigan State Medical Society has urged continuation of the present policy of admission to medical schools based solely on merit and aptitude to gain the best qualified and maximum number of doctors, regardless of ancestry, race or creed: Therefore be it

RESOLVED, That the Michigan State Medical Society continue and increase its efforts to gain further funds from the Michigan legislature and from the people of the State of Michigan, by concentrated drives and through contacts on a permanent basis for contributions, to the end that: (a) adequate facilities (school buildings) are supplied the two medical schools in Michigan; and (b) necessary additions to the faculty of these two Grade A schools of Michigan are made by routinely training a requisite per cent of each medical school class to become teachers; and be it

RESOLVED further, That the Michigan State Medical Society offer its co-operation to the presidents and medical deans of the University of Michigan and Wayne University for the development of an aggressive and early campaign to secure from the State of Michigan and from alumni and other citizens who are interested in better health, funds necessary to enlarge medical facilities and faculties in this state to the end that the resulting increase in the number of medical graduates from the University of Michigan and Wayne University is sufficient to continue to give adequate and good quality medical care to the people of this state.

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

X—e. SUPPLEMENTARY X-RAY AND ELECTRO-CARDIOGRAPHIC SERVICE CERTIFICATE OF MICHIGAN MEDICAL SERVICE

F. D. JOHNSON, M.D. (Genesee): I have been instructed by members of the Genesee Medical Society to present the following resolution:

This resolution was presented but subsequently withdrawn and redrafted (see Page 47).

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

X—f. ENCOURAGING ADDITIONAL FUNDS FOR WAYNE COUNTY COLLEGE OF MEDICINE

W. W. Babcock, M.D. (Wayne): This has been requested to be presented by the Wayne delegation:

Whereas, the present world situation appears to demand a lasting increase in the Armed Forces of the United States and consequently an increased need for medical personnel for an unpredictable length of time; and

Whereas, there already exists some shortage of physisians, not only for the Armed Forces but also for civilian needs; and

Whereas, attempts to increase the educational facilities of Wayne University Medical School have fallen far short of the reasonable goals in spite of the fact that there is a wealth of unused clinical material in Wayne County; and

Whereas, funds for the maintenance of such medical educational facilities as are already provided are barely adequate to furnish a minimum of teaching and research personnel: Therefore be it

Resolved, That The Council of the Michigan State Medical Society direct suitable efforts toward securing further funds from the State of Michigan for the maintenance of the Wayne University Medical School, the second and only other medical school in the state.

The Speaker: This will be referred to the Reference Committee on Legislation and Public Relations.

XI. Amendments to Constitution and By-laws

XI—a. BY-LAWS CH. 5—SEC. 9—RE QUALIFICATIONS FOR SPECIAL MEMBERSHIPS

R. W. Teed, M.D. (Washtenaw): The Executive Council of the Washtenaw County Medical Society has instructed its delegation to present the following resolution regarding the By-laws:

Whereas, the By-laws relating to election of members of the Michigan State Medical Society to Retired, Emeritus and Life Membership are indefinite on a certain point; and

Whereas, a member qualifying for Retired, Emeritus or Life Membership during the interval between the fall meeting of the House of Delegates and the beginning of the following fiscal year would be required to pay dues the following year in order to maintain active membership; and

Whereas, such provision has already worked a hardship in the Washtenaw County Medical Society: Therefore be it

Resolved, That Chapter 5, Section 9 of the By-laws of the Michigan State Medical Society be amended as follows: After the words: "Annual Session of the House of Delegates," the following sentence be inserted: "Such certification shall be valid for a period of 12 calendar months, during which time the applicant shall not be required to pay dues."

The Speaker: That will be referred to the Reference Committee on Constitution and By-laws.

X—g. STUDY OF NURSING NEEDS

E. C. Long, M.D. (Wayne):

Whereas, little effort has been made to determine what type of nursing services the public needs; and

Whereas, nursing training programs have developed which do not fill these needs: Therefore be it

Resolved, That an effort be made to ascertain what are the public needs in regard to nursing services and to develop a program that would provide such services.

The Speaker: I will refer this to the Reference Committee on Resolutions.

X—h. RECOMMENDING CHANGE IN CORONER SYSTEM

D. G. Pike, M.D. (Grand Traverse-Leelanau-Benzie):

Whereas, the present duties of the county coroners make essential that the coroner be an individual with medical knowledge; and

Whereas, under the present system any individual may run for coroner by petition to the county clerk's office; and

Whereas, the present coroner system is a carry-over of old English law and is outdated and outmoded; and

Whereas, many states in our Union of the United States have abolished the coroner system in favor of a properly appointed county medical examiner system: Therefore be it

Resolved, That the Michigan State Medical Society initiate action in attempting to legislate a change in our present coroner system and the adoption of a system of appointed medical examiners who are qualified doctors of medicine.

The Speaker: That will be referred to the Reference Committee on Legislation and Public Relations.

X—i. URGING DEVELOPMENT OF A SIMPLIFIED INSURANCE REPORTING FORM

D. G. Pike, M.D. (Grand Traverse-Leelanau-Benzie):

Whereas, the completion of blanks for health, accident and hospital insurance is becoming so prominent a part of the daily duties of physicians; and

Whereas, the insurance company depends entirely upon the written report of the attending physician for the basis of evaluating and settling claims; and

Whereas, in some instances these report forms are long, involved, repetitious and confusing, requiring considerable time in checking records and in filling out these forms: Therefore be it

Resolved, That the Grand Traverse-Leelanau-Benzie County Medical Society request the Michigan State Medical Society to develop a simplified reporting form which could be used by all insurance companies doing business in Michigan; and be it

Resolved further, That in those instances in which an insurance company insists on a special long, complicated form our membership shall be privileged to make a reasonable charge direct to the company for the completion of such forms.

The Speaker: I will refer this to the Reference Committee on Resolutions.

X—j. REIMBURSEMENT OF ATTENDING PHYSICIANS BY MICHIGAN MEDICAL SERVICE

R. F. Fenton, M.D. (Wayne): This resolution is at the request of the Board of Directors of the Wayne County Academy of General Practice.

WHEREAS, Michigan Medical Service does not pay for both medical and surgical care on its medical surgical contract paying only the consultant and

WHEREAS, It is unethical for the consultant to split fees and

WHEREAS, Surgical fees have been intermittently increased during the past nine years with no attempt being made to pay the attending physician, Therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society request from the Michigan Medical Service that there be no additional increase of surgical fees in any contract until some method has been devised for reimbursing the attending physician in hospitalized cases referred to consultants.

The Speaker: This will be referred to the Reference Committee on Medical Service and Pre-payment Insurance.

XI—b. BY-LAWS CH. 5—SEC. 7—RE QUALIFICATIONS OF LIFE MEMBERS

E. D. SPALDING, M.D. (Wayne):

WHEREAS, the present By-laws in Chapter 5, Section 7, concerning Life Membership, state: "A doctor of medicine who has attained the age of 70 years and maintained an active membership in good standing for 25 consecutive years in the State Society may upon his application and recommendation of his component county society, be transferred to the Life Members' roster"; and

WHEREAS, a number of Michigan doctors of medicine who have attained the age of 70 years, have maintained active membership in good standing in the Michigan State Medical Society for 25 years and longer, but due to a break in the record this membership has not been 25 "consecutive years"; and

WHEREAS, the present use of the word "consecutive" in Chapter 5, Section 7 constitutes a hardship on these men who otherwise have attained qualifications for Life Membership in the Michigan State Medical Society: Therefore be it

RESOLVED, That Chapter 5, Section 7, Life Member, be amended by deletion of the word "consecutive," so that the section will read as follows:

"Section 7—Life Member: A doctor of medicine who has attained the age of 70 years and maintained an active membership in good standing for 25 years in the State Society may, upon his application, and recommendation of his component county society, be transferred to the Life Members' roster."

THE SPEAKER: This will be referred to the Reference Committee on Constitution and By-laws.

XII. Reports of Standing Committees

L. A. DROLETT, M.D. (Ingham): While I am talking, there will be distributed to you a pamphlet which I want you to read carefully.

XII—a. SUPPLEMENTARY REPORT OF THE LEGISLATIVE COMMITTEE

We of the medical profession, both in Michigan and in the entire country, have openly declared War on Socialism, the twin brother of Communism. Aroused by the threat of Socialized Medicine and its attendant dangers, we have come to the realization that those who would socialize America are intent upon doing it step by step, piece by piece, conquering by dividing the forces that oppose them. We must conclude that the only answer is a united front by all forces opposing socialization . . . the aligning together of all American groups who believe in the American way of life in a concerted effort to stop the creeping tide and to regain the ground already lost.

We are taking such a course in Michigan. Thirty-two statewide organizations have joined with us in the "Good Citizenship" campaign. The Michigan State Medical Society was responsible for the resultant movement which ended in the greatest influx of voters to the polls in the September 12th Primary Election that has ever been known in an off year election in Michigan. As the leader the medical profession did itself proud by gaining a registration of over 97 per cent of the members of the MSMS and their wives, and over 90 per cent of their assistants.

But let us not fool ourselves that we were *entirely* responsible for the record turnout of voters. In Detroit and certain other metropolitan areas the labor vote was phenomenal. There *is no* reason to decry this. There *is* reason to recognize that we have more than matched that vote and that we *must not fail* to better our record in the November 7 General Elections.

On the week of October 8 a gigantic advertising campaign will flame throughout the nation. The American Medical Association is spending a million and one quarter dollars of our money to call to the attention of the American People that the "Voluntary Way is the American Way." They are being joined by hundreds and thousands of other organizations and businesses who believe that slogan to be true.

Let me quote from a clipping recently distributed by the AMA of a newspaper release appearing in the *Chicago Daily Tribune* (read clipping as marked). It is obvious from the propaganda being issued that Mr. Stellato has *not* succeeded.

We cannot stop the scurrilous and contemptible tactics of our opponents. But we can beat them in getting out the vote. We can elect to office men who will not be swayed by their demands. We have already had public repudiation of compulsory Health Insurance and Socialized Medicine by men whose political party is committed by President Truman to its enactment.

You have nominated such men in the primaries. I invite to your attention the fact that they have *not yet* been elected. In the next legislature and next Congress, we shall need more than ever before the highest caliber of men.

We have committed ourselves. We must win in November, or we shall have more than lost face, we shall have lost our country.

Let us take off our rubber gloves and start swinging.

THE SPEAKER: The supplemental report, in addition to the regular report of the Legislative Committee, will be referred to the Reference Committee on Standing Committees.

THE VICE SPEAKER: Reports of Standing Committees.

XII—b. COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

Page 61 of the handbook.

XII—c. THE PREVENTIVE MEDICINE COMMITTEE

XII—d. RHEUMATIC FEVER CONTROL COMMITTEE

Page 68 of the Handbook.

XII—e. CANCER CONTROL COMMITTEE

Page 71 in the Handbook.

XII—f. MATERNAL HEALTH COMMITTEE

Page 75 in the Handbook.

XII—g. VENEREAL DISEASE CONTROL COMMITTEE

Page 76 in the Handbook.

XII—h. TUBERCULOSIS CONTROL COMMITTEE

No printed report.

XII—i. INDUSTRIAL HEALTH COMMITTEE

Page 78 in the Handbook.

XII—j. MENTAL HYGIENE COMMITTEE

Page 80 in the Handbook.

XII—k. CHILD WELFARE COMMITTEE AND SUB-COMMITTEE ON HEARING DEFECTS

Page 81 in the Handbook.

XII—l. IODIZED SALT COMMITTEE

Page 83 in the Handbook.

XII—m. GERIATRICS COMMITTEE; SUB-COMMITTEE ON DIABETES CONTROL, AND SUB-COMMITTEE TO STUDY PROBLEMS OF CARING FOR AGED

Page 83 in the Handbook.

XII—n. COMMITTEE ON INFECTIOUS DIARRHEA

XII—o. COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

Page 84 in the handbook.

XII—p. COMMITTEE ON PUBLIC RELATIONS AND THE SUB-COMMITTEES

Printed in the Handbook.

XII—q. COMMITTEE ON ETHICS

XII—r. THE LEGISLATIVE COMMITTEE

All of the reports of the Standing Committees will be referred to the Reference Committee on Standing Committees.

XIII. Reports of Special Committees

XIII—a. THE BEAUMONT MEMORIAL COMMITTEE

XIII—b. SCIENTIFIC RADIO COMMITTEE

XIII—c. ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

XIII—d. LIAISON COMMITTEE WITH STATE MEDICAL ASSISTANTS SOCIETY

XIII—e. ADVISORY COMMITTEE TO NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

XIII—f. COMMITTEE ON INCREASE OF MEDICAL STUDENTS GRADUATED FROM MICHIGAN MEDICAL SCHOOLS

E. F. SLADEK, M.D. (Grand Traverse-Leelanau-Benzie): This report, as printed in the handbook, was formulated in May, I believe. The legislature was still in session and we expected that there would be a grant to the University of Michigan for an out-patient department, so as to enable an increase in the number of medical students to the figure of 200, which is in this report. Unfortunately, the legislature did not see fit to grant funds, and so as of fifteen minutes ago the number of students entering the University of Michigan is 160. Last year's class was 150. They have crowded in an additional ten students. The number that have entered the freshman class at Wayne as of fifteen minutes ago is 68.

We are hoping that expanded facilities through legislative support will materially increase the number of admissions to these two medical schools.

THE VICE SPEAKER: The supplemental report of the Committee on Increase of Medical Students Graduated from Michigan Medical Schools, together with their regular report and the reports of all the Special Committees will be referred to the Reference Committee on the Reports of Special Committees.

The session adjourned at 3:30 p.m.

MONDAY EVENING SESSION

September 18, 1950

The House of Delegates reconvened at 8:25 p.m.

THE SPEAKER: We have allotted a little time to Dr. Earl I. Carr of Lansing, who would like to talk to us on some recent activity by the Michigan Foundation for Medical and Health Education, Inc. Dr. Carr has a message for us on some new developments within the organization and some plans that, inasmuch as we are a part of and have been a contributor in getting the thing going, we should be acquainted with.

Dr. Carr presented a prepared report.

X—e. SUPPLEMENTARY X-RAY AND ELECTROCARDIOGRAPHIC SERVICE CERTIFICATE OF MMS

C. K. STROUP, M.D. (Genesee): This morning Genesee introduced a resolution which the Resolutions Committee requested to be reworded and resubmitted. I therefore present this reworded resolution:

WHEREAS, Michigan Medical Service now issues a supplementary x-ray and electrocardiographic service certificate only to holders of a Michigan Hospital Certificate which, through a series of bookkeeping steps, in effect places the Michigan Hospital Service in the position of insuring a service which the American Medical Association has just reaffirmed is a medical service; and

WHEREAS, the AMA has specifically stated that hospital service contracts should cover only hospital services as published in the JAMA, July 22, 1950, page 1091: Therefore be it

RESOLVED, That the Michigan State Medical Society instruct its delegates who are members of Michigan Medical Service to take necessary steps to have Michigan Medical Service desist as a party to a practice contrary to the policy of the American Medical Association.

THE SPEAKER: You understand this is a substitution for the resolution presented this morning, and is to be referred to the Reference Committee on Resolutions.

X—k. CREATING SECTION ON GASTROENTEROLOGY AND PROCTOLOGY

E. F. SLADEK, M.D. (Grand Traverse-Leelanau-Benzie):

WHEREAS, there is an ever-increasing interest in diseases of the anus, rectum and colon; and

WHEREAS, there are more doctors of medicine devoting their efforts in all or part to these conditions; and

WHEREAS, a section in the Scientific Assembly of the Michigan State Medical Society on the subject of rectal and colon diseases could contribute greatly to the scientific program of the State Society and its Postgraduate Institute; and

WHEREAS, there is now a Michigan Proctologic Society: Therefore be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society approve the development of a Section on Proctology.

THE SPEAKER: This will be referred to the Reference Committee on Constitution and By-laws.

XIV—Reports of Reference Committees

XIV—a. REFERENCE COMMITTEE ON OFFICERS' REPORTS

(1) Speaker's Address
(2) President's Address
(3) President-Elect's Address
(4) AMA Delegate's Report

C. W. Oakes, M.D., presented the report.

Your Reference Committee on Officers' Reports considered the Speaker's Address, the President's Address, the President-Elect's Address and the report of the Delegates to the AMA.

1. *Speaker's Address*

We wish to compliment Doctor Baker on his excellent address. It was most scholarly and well given.

2. *President's Address*

President Barstow summarized the year's work with

special emphasis on the improvement of public relations. We wish to thank Dr. Barstow for this fine address.

3. *President-elect's Address*

President-elect Umphrey's address is a look into the year ahead. He stressed our problems and presented them to us in a most excellent manner.

4. *The report of the Delegates to the AMA*

The report of the Delegates to the AMA was given by Doctor Novy in place of Doctor Barrett, who is ill.

The report consisted of two parts.

(a) The interim meeting in Washington, D. C.

(b) The regular meeting in San Francisco.

We wish to thank the delegates for their hard work.

C. W. Oakes, M.D. (Huron): I move the adoption of this report as a whole.

W. W. Babcock, M.D. (Wayne): I second the motion.

Motion carried.

XIV—b. REFERENCE COMMITTEE ON REPORTS OF THE COUNCIL

C. K. Hasley, M.D. (Wayne): The Reference Committee has very carefully studied the reports of The Council as contained in the handbook for delegates and the supplemental report as given by the Council Chairman, O. O. Beck, M.D.

The committee notes with interest the amount of time that members of The Council and its Executive Committee have devoted in the interests of the Michigan State Medical Society. Their efforts are greatly appreciated by this committee.

The committee approves the financial report as presented.

The committee approves the various activities of The Council as reported in the Handbook.

The innovation in The Journal was noted and felt that it should be continued so that the latest information on Michigan Medical Service and Michigan Hospital Service is available to all members of the MSMS.

The recommendations of The Council were carefully considered. There is a little overlapping in the reports in the handbook and the supplementary report. We will take them up as they are in the supplementary report. There are a few additions.

Recommendation of The Council, No. 1. I move the adoption of this recommendation:

1. That each and every member of the MSMS continue to co-operate wholeheartedly, both by individual action and financially, to aid the AMA and its National Education Campaign in a program of active and direct resistance against any attempt to throw the practice of medicine into politics. The past loyalty of Michigan's medical men toward the AMA is highly commended. Michigan stands in the forefront of those states whose voluntary help to our parent organization is near the 100 per cent mark.

If I may, I would like to include in my motion three or four other recommendations. Unless there is objection, I will present them as a whole.

2. That representatives of the MSMS be instructed to continue their yearly visit to Washington, D. C., on the occasion of Michigan Day sponsored by the United States Chamber of Commerce.

3. That newspaper and magazine editors and features writers who have and are publishing splendid articles, factual news stories and strong editorials against socialism be sent official letters of commendation. That pertains particularly to members of the Society; not The Council itself, but individual letters.

4. That the By-laws be changed so that the word "consecutive" in the section on Life Membership (Chapter 5, Section 7) is deleted.

It is my understanding that a resolution has been introduced to that effect.

I move the adoption of this part of the report.

G. C. Stucky, M.D. (Eaton): I second the motion.

Motion carried.

C. K. Hasley, M.D. (Wayne): Recommendation No. 6 is the one that has to do with the change in dues, the recommendation that the yearly dues should be $50. The committee felt that a word of explanation should be given on how this amount was derived. The dues have been $12 a year, and it was felt this amount was inadequate. It was necessary by a special vote of the House of Delegates to use $5 given to the Educational Fund to make up the deficit. It is the opinion of the members of The Council that this is an inadequate amount to run on, and that at least $20 would be needed to carry on the activities of the Society.

In addition to that, in the past years we have had our $25 special assessment for the Educational Fund. However, it was felt that if this were all lumped into one sum and called dues for the Society that it would from a legal standpoint be much better. Also, the amount would be deductible for income tax purposes.

Consequently, we have felt that perhaps $50 was a little bit more than was necessary. In talking with some of the members we found they felt if the amount of $45 was set and this should be set as the dues for the coming year, that probably it would meet the favor of most of the members of the Michigan State Medical Society.

Therefore, I move, Mr. Speaker, that the dues for next year be set at $45 for the year.

C. K. Stroup, M.D. (Genesee): I second it.

The Speaker: Is there any discussion?

H. M. Riecker, M.D. (Washtenaw): What would be the dues of the associate members?

C. K. Hasley, M.D. (Wayne): There would be no change in the relationship of associate members. This is just the active members.

E. H. Fenton, M.D. (Wayne): It seems to me that the raise in dues should not include the first five years in practice. It seems quite a bit for some of the men who are just getting started. If we could put a rider on that and eliminate the raise for the first five years in practice, keeping the dues the same as they are at the present time, and then increase the dues after the first five years, it would be perfectly acceptable. However, I think it is wrong to place dues that high on a man just getting started in practice.

The Speaker: Are there any other suggestions?

D. H. Kaump, M.D. (Wayne): It seems to me peculiar, Mr. Speaker, that the total sum of dues should be raised from $37 to $50 in one year. In other words, a 35 per cent increase in dues in one year is quite a bit. If we were able to get along on $37 before, why would not some smaller raise, such as $8 or $10 be adequate? If we can get along on less why not make the dues less, rather than raise them to an exorbitant amount?

C. K. Hasley, M.D. (Wayne): If I may attempt to answer that question, it has been explained that the program that is contemplated is rather large and the amount of money that is going to be necessary to carry on is larger; in the event that there is a nest egg, that can be used for the idea about establishing a permanent home for the Michigan State Medical Society, an office building, or something like that. There will be plenty of places where money can be used later. We need that sum for emergency purposes. The $45 would give just a little above the red line, so to speak.

D. H. Kaump, M.D. (Wayne): But to increase the dues a third at one time seems like a big step.

C. K. Hasley, M.D. (Wayne): It has been necessary to take some of the money from funds allocated for other purposes in order to carry on the business functions of the Society.

C. R. Gatley, M.D. (Oakland): I think there is some ground for this statement about the men first starting out being allowed a lower rate. Some of the men just starting out have families and small children.

Part of the reason for saying that is the necessity for their having membership in the county society. Recently, we had a man starting up in our town, after a one-year internship, with a wife and family. He was refused for a considerable time being able to bring cases under his own name until he joined the county society, and the like. I think the first year some consideration should be given to those men. They perhaps need that money more than we do.

J. H. SCHLEMER, M.D. (Wayne): Just what brake do we have upon the expenditures of the Public Relations Committee? It seems to me that we should have some ceiling on it. Otherwise, they could expand indefinitely, and next year we might have another increase in dues.

C. K. HASLEY, M.D. (Wayne): The idea of setting this at $45 was that there would be no need for special assessments. Of course, another thing we have not taken into consideration yet is that some of the members are being called to military service and there will be a loss of revenue from that standpoint.

The committee would be very happy if someone wanted to offer an amendment to this motion for a year or two. We can incorporate it with the motion at this time.

E. H. FENTON, M.D. (Wayne): I would like to make an amendment to the motion, that dues remain the same for the first five years in active practice, and beyond that that the increase as suggested be granted.

THE SPEAKER: Is there a second to the amendment?

F. A. WEISER, M.D. (Wayne): I second it.

G. E. TOSHACH, M.D. (Saginaw): I think if we make that for five years we are going to hamstring our Public Relations Committee. I certainly have a very kindly feeling toward the men starting in practice, but it seems to me that one year is sufficient. After that most men are making a living, and while it is a great strain to carry the burden at that time the work that is going to be done by the Public Relations Committee is going to do those men a lot more good than the men of my age, so they have more at stake. They ought to be willing to pay it at least after the first year. I would like to make an amendment to the amendment that this be for one year.

R. A. SPRINGER, M.D. (St. Joseph): I second it.

THE SPEAKER: There is an amendment to the amendment that the exemption of the increased dues be restricted to one year instead of five. Is there discussion on that?

H. W. WILEY, M.D. (Ingham): I raise for a point of clarification the question of what they refer to as dues. Our dues have been $12, with the special assessment of $25, which makes an aggregate of $37. In the amendment do you refer to the dues as $12 or the aggregate of $37?

THE SPEAKER: I wish the maker of the amendment would clarify exactly what he means, in view of Dr. Wiley's remarks. Just what do you consider the basic dues at the moment?

E. H. FENTON, M.D. (Wayne): I was not considering the assessment as dues. The $25 assessment has never been considered as dues. The dues are $12.

THE SPEAKER: Then you would relieve these young members not only of any increase, but also of the assessment, or would you continue the assessment?

E. H. FENTON, M.D. (Wayne): That is right.

THE SPEAKER: The ruling has been that the assessment is part of the dues, so you would have to stay back at the present level for the one-year men. Is there any other discussion? Are you ready for a vote?

C. I. OWEN, M.D. (Wayne): I move that this be referred back to the committee for further elucidation and proper clarification, and returned tomorrow morning.

H. H. RIECKER, M.D. (Washtenaw): I second the motion.

Motion carried.

C. K. HASLEY, M.D. (Wayne): This pertains to just the one recommendation, No. 7, of The Council.

7. That the House of Delegates as a whole and each delegate as an individual use all efforts to the end that every county medical society in Michigan has an active Mediation Committee so that any complainant may be apprised of the fact that there is available in every county medical society a Mediation Committee to which the complainant may make reference in writing in case of alleged "dispractice."

The Reference Committee approves this recommendation and it is hoped that more of the component medical societies will appoint Mediation Committees. I move the adoption of this recommendation.

J. H. SCHLEMER, M.D. (Wayne): I second it.

Motion carried.

C. K. HASLEY, M.D. (Wayne): Recommendation No. 8:

8. That county medical societies give priority to programs, during the ensuing months, which teach evacuation and disaster techniques and which explain the medical-industrial uses of atomic energy, in the preparation of which programs the assistance of the MSMS Emergency Medical Service Committee and the MSMS Committee on Atomic and Allied Procedures is offered.

The Reference Committee most heartily endorses this recommendation and stresses the importance of each county medical society availing itself of these programs. I move the adoption of this part of the report.

THE SPEAKER: Is there a second to the motion?

(The motion was severally seconded.)

Motion carried.

C. K. HASLEY, M.D. (Wayne): I move the adoption of the report as a whole, with the exception of Recommendation No. 6.

M. A. DARLING, M.D. (Wayne): I second it.

Motion carried.

XIV—c. REFERENCE COMMITTEE ON STANDING COMMITTEES

P. E. SUTTON, M.D. (Oakland): We appreciate that the reports of the Standing Committees represent a tremendous volume of work, a tremendous amount of energy by a great number of individuals, and it goes without saying that we recognize and appreciate the work that is done by these committees.

As far as we could see from reading the reports and our knowledge of the work done by these committees, we could find no controversial reports, with one or two exceptions. Therefore, the main body of our report is very brief. I hope, however, that you will all take the time to read for yourselves the reports of these committees in the Handbook, pages 61 to 99.

The Reference Committee on Reports of Standing Committees recommends the acceptance of the Annual Report of the Committee on Postgraduate Medical Education. The Reference Committee also recommends the acceptance of the supplemental report.

I move the acceptance of this recommendation.

B. M. HARRIS, M.D. (Washtenaw): I second it.

Motion carried.

P. E. SUTTON, M.D. (Oakland): I might give you a brief clarification of this. There are six committee recommendations, six committee reports. The subcommittees within these six come to a total of twenty subcommittees.

The next item is the report of the Preventive Medicine Committee and all of its subcommittees. The Reference Committee recommends the acceptance of the annual report of the Committee on Preventive Medicine and its subcommittees.

I move the adoption of this recommendation.

B. M. HARRIS, M.D. (Washtenaw): I second it.

Motion carried.

P. E. SUTTON, M.D. (Oakland): The third report has to do with the Public Relations Committee. The

Reference Committee recommends the acceptance of the annual report of the Public Relations Committee and its subcommittees.

I move the adoption of the report.

R. W. TEED, M.D. (Washtenaw): I second it.

Motion carried.

P. E. SUTTON, M.D. (Oakland): The fourth has to do with the annual report of the Committee on Distribution of Medical Care. The report states that there were no problems referred to the Committee on Distribution of Medical Care. Therefore, the Reference Committee recommends the acceptance of the report.

J. H. SCHLEMER, M.D. (Wayne): I second it.

Motion carried.

P. E. SUTTON, M.D. (Oakland): The fifth item is the annual report of the Ethics Committee. The Ethics Committee reports that there have been no problems referred to its committee. We recommend the acceptance of the report, and I move the adoption of the report.

R. E. DUSTIN, M.D. (Lenawee): I second it.

Motion carried.

P. E. SUTTON, M.D. (Oakland): The sixth and final item is the annual report of the Legislative Committee and the supplementary report which was given to us this morning at the meeting. The Reference Committee recommends the acceptance of the annual report and recommends the deletion of the supplementary report you heard read this morning.

In support of our recommendation, you remember seeing this Exhibit A this morning. There are two pages of typed report and the supplementary report. We recommend the deletion of the supplementary report, and the acceptance of the printed annual report of the Legislative Committee.

I move the adoption of the annual report.

THE SPEAKER: I understand the committee moves the adoption of the Legislative Committee report, as printed, and the deletion of the supplementary report.

B. M. HARRIS, M.D. (Washtenaw): I second it.

Motion carried.

P. E. SUTTON, M.D. (Oakland): I move the adoption of the report as a whole, Mr. Speaker.

R. W. TEED, M.D. (Washtenaw): I second it.

Motion carried.

THE SPEAKER: Now, Dr. Harris, would you like to give the other half of the committee report, the Reference Committee on Special Committee reports?

B. M. HARRIS, M.D. (Washtenaw): I think Dr. Sutton has already explained the membership of the committee.

XIV—d. REFERENCE COMMITTEE ON REPORTS OF SPECIAL COMMITTEES

We recommend the acceptance of the Annual Report of the Beaumont Memorial Committee, with an expression of sympathy to the committee on their inability to accomplish their mission, and urge the continuation of efforts to the same end.

I move the acceptance of that.

P. E. SUTTON, M.D. (Oakland): I second it.

Motion carried.

B. M. HARRIS, M.D. (Washtenaw): The Reference Committee recommends approval of the annual report of the Scientific-Radio Committee, as printed on pages 100 and 101 of the Handbook.

I move the acceptance of this report.

P. E. SUTTON, M.D. (Oakland): I second it.

Motion carried.

B. M. HARRIS, M.D. (Washtenaw): The Reference Committee recommends approval of the annual report of the Advisory Committee to the Woman's Auxiliary, as printed on page 101 of the Handbook.

I move the acceptance of this report.

C. K. STROUP, M.D. (Genesee): I second it.

Motion carried.

B. M. HARRIS, M.D. (Washtenaw): The Reference Committee recommends the approval of the annual report of the Liaison Committee of the Michigan State Medical Society Assistants' Society, page 110 of the Handbook.

I move the acceptance of that report.

J. H. SCHLEMER, M.D. (Wayne): I second it.

Motion carried.

B. M. HARRIS, M.D. (Washtenaw): The Reference Committee recommends the approval of the annual report of the MSMS Advisory Committee to the National Foundation for Infantile Paralysis. I move the acceptance of that report.

C. I. OWEN, M.D. (Wayne): I second it.

Motion carried.

B. M. HARRIS, M.D. (Washtenaw): The Reference Committee recommends the approval of the annual report of the Committee on Increase of Medical Students Graduated from Michigan Medical Schools.

I move the acceptance of that report.

D. B. WILEY, M.D. (Macomb): I second it.

Motion carried.

B. M. HARRIS, M.D (Washtenaw): I move the acceptance of the report of the Reference Committee on reports of Special Committees as a whole.

C. K. STROUP, M.D. (Genesee): I second it.

Motion carried.

XIV—e. REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

1. Report of Committee to Study Councilor Districts

C. I. OWEN, M.D. (Wayne): We were given three resolutions for study. The first was a report of the special committee to study Councilor Districts. In substance the report concerns a revision of the Councilor Districts. It was the general concensus of the subcommittee that there be no major revision of Councilor Districts at this time. In this the committee agrees, and recommends that there be no major revision at this time.

The special committee recommended two changes in counties: The change of Kalkaska County to District 9 from District 10, and they recommend the change of Clinton County to District 2 from District 6. They also recommended that the counties concerned be given an opportunity to make their opinions known.

As our final report on their report, the committee unanimously endorses the report of the special committee to study Councilor Districts, including the recommendation that no major reallocations of the Councilor Districts be made at this time.

In accordance with the recommendation of the committee it is recommended that each county society in Councilor Districts Nos. 9 and 10 be requested for an opinion concerning the removal of Kalkaska County to Councilor District 9 from Councilor District 10, and that the county submit their opinion to the Council of the Michigan State Medical Society by June 1, 1951. That would give opportunity for action next year.

The same recommendation is made in regard to the change of Clinton County from District 2 to District 6; that all county societies in those districts be notified so they can make a study and submit their opinion by June 1, 1951.

I move that this be adopted.

G. C. STUCKY, M.D. (Eaton): I second it.

Motion carried.

XI—c. BY-LAWS CH. 8—SEC. 10 (g)—ELECTION OF COUNCILORS

C. I. OWEN, M.D. (Wayne): There is another recommendation by the special committee to study Councilor Districts. That is that some consideration be given to advising counties where new Councilors are needed. Every five years a Councilor is elected from the district. He is elected on recommendation of the component societies. It was also thought by the special committee

that when a vacancy occurs during annual meetings such as this, when the Councilor may be kicked upstairs to another job and a vacancy is created, that the delegates of the counties of that district should be given time to have a caucus to make a recommendation. In order to accomplish that it is necessary to amend the By-laws.

If you turn to page 140 of the Handbook, Chapter 8, Section 10, paragraph (g), it reads:

"It shall elect the Councilors upon the nomination of the delegates of the Councilor District whose Councilor's term expires, as hereinafter provided."

That is part of the regular election. We are recommending the addition of two sentences to that paragraph, as follows:

"Component county societies of Councilor Districts shall be notified in writing by the Secretary of the State Society 60 days in advance of the Annual Meeting when a Councilor is to be elected from their district at the expiration of the usual term. If a vacancy in The Council occurs during an Annual Meeting of the Michigan State Medical Society, the delegates of the component county societies will be given time in which to conduct a caucus in order to consider nomination(s) for the vacancy."

That is proposed as an amendment to the By-laws. Dr. Foster says it is presented at this time as an amendment, to be acted on tomorrow.

XIV—e (3). BY-LAWS CH. 5—SEC. 7

Then we had a resolution to change the By-laws, Chapter 5, Section 7, to delete the word "consecutive" from about the middle of the section. The Section 7 as amended would read as follows:

"Life Member—A Doctor of Medicine who has attained the age of seventy years and maintained an active membership in good standing for twenty-five years in this State Society may, upon his application, and recommendation of his component County Society, be transferred to the Life Members' Roster," and so forth.

Just the one word is taken out, "consecutive." That is to provide for men who have dropped their membership for a year or two, for one reason or another, and then resumed it. Previously those men could not qualify.

I recommend the adoption of this amendment to the By-laws.

THE SPEAKER: Is there a second to that?

F. A. WEISER, M.D. (Wayne): I second it.

Motion carried.

XIV—e (4). BY-LAWS CH. 5—SEC. 9

C. I. OWEN, M.D. (Wayne): The third resolution presented to us was the one presented by Dr. Teed of Washtenaw County, for the Washtenaw County Medical Society.

WHEREAS the By-laws relating to election of members of the Michigan State Medical Society to Retired, Emeritus and Life Membership are indefinite on a certain point; and

WHEREAS a member qualifying for Retired, Emeritus or Life Membership during the interval between the fall meeting of the House of Delegates and the beginning of the following fiscal year would be required to pay dues the following year in order to maintain active membership; and

WHEREAS such provision has already worked a hardship in the Washtenaw County Medical Society: Therefore be it

RESOLVED, That Chapter 5, Section 9 of the By-laws of the Michigan State Medical Society be amended as follows: After the words "Annual Session of the House of Delegates," the following sentence be inserted: "Such certification shall be valid for a period of 12 calendar months, during which time the applicant shall not be required to pay dues."

It is recommended by the committee that this resolution not be adopted. In a word of explanation I might say that there might be an occasional hardship in which case the county society concerned could afford to pay the man's membership. If this were adopted it would open a flood gate; pretty soon it would be two years, three years. The committee felt it was all right just as it is. Maybe we have given too many millionaires free memberships as it is.

THE SPEAKER: The motion is recommending rejection of the resolution. Is there a second?

E. D. SPALDING, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion?

O. K. ENGELKE, M.D. (Washtenaw): I believe this recommendation of the committee should not be adopted. I wish all of you could have been on the Washtenaw County Medical Society's Technical Committee for the past few years, when it developed that it was not a matter of the few dollars involved, but a matter of principle. I assure you it was not a matter of a few dollars that the Society would not put up that prompted the drafting of the resolution which, so help me, I cannot believe will disrupt the operation of the Michigan State Medical Society, but it has disrupted the operation of the Executive Council of the Washtenaw County Medical Society for quite a while.

I do not believe the objections of the committee are valid. I wonder if they have any other objections?

C. I. OWEN, M.D. (Wayne): We have no other. We saw no reason to change it. We think if this is adopted, pretty soon it will be two years, and then maybe three years, and perhaps then there won't be anybody paying dues.

O. K. ENGELKE, M.D. (Washtenaw): I submit that no such resolution was presented.

R. J. ARMSTRONG, M.D. (Kalamazoo): I would like to second the opinion of the Washtenaw County group, in the plea of making common sense. If a man has paid his dues in 1950 and retires after this session because of illness, he certainly is entitled to be considered as a retired member, even though this House does not meet until next year.

THE SPEAKER: Is there further discussion?

H. H. RIECKER, M.D. (Washtenaw): Is there a motion before the House that could be superseded?

THE SPEAKER: There is a motion before the House that this be rejected. This is a discussion of the motion.

H. H. RIECKER, M.D. (Washtenaw): I would like to second that motion.

C. K. STROUP, M.D. (Genesee): We just voted to delete from the By-laws the word "consecutive," in the motion just before this one. We were in error on that because it is a change in the By-laws. I believe again we are talking about the By-laws and that this cannot be voted on until it has been tabled for one session.

C. I. OWEN, M.D. (Wayne): This motion is not an amendment to the By-laws. This is a motion to turn down the resolution.

THE SPEAKER: You are correct on the other, however, that that should lay over until the next meeting to be voted upon. However, this is a motion to turn down the recommendation. Are you ready for the question?

Call for the question. Motion carried.

H. H. RIECKER, M.D. (Washtenaw): I move that the report of the Constitution and By-laws Committee concerning this matter be referred back to the committee for reconsideration.

R. A. SPRINGER, M.D. (St. Joseph): I second it.

THE SPEAKER: It does not have to be referred back. It will come up tomorrow automatically as an amendment to the By-laws. You will have a chance to vote on it then.

XIV—f. REFERENCE COMMITTEE ON RESOLUTIONS

The Reference Committee on Resolutions recommends to the House of Delegates the adoption of the resolution, with a slight addition. The resolution will then read as follows, leaving out the Whereas clauses:

XIV—f. 1. Urging Medical Society to Exercise right of franchise

RESOLVED, That the Michigan State Medical Society call upon its members to exercise their right of franchise on November 7, 1950, and on all future opportunities and to persuade their families, patients and friends to do likewise.

The change in the resolution is in regard to the statement, "and on all future opportunities."

I move the adoption of this report.

H. B. FENECH, M.D. (Wayne): I second it.

Motion carried.

XIV—f. 2. Supporting the United Nations

G. T. MCKEAN, M.D. (Wayne): The Reference Committee on Resolutions recommends to the House of Delegates the adoption of the resolution with a slight change, again in the Resolve, as follows:

RESOLVED, That the Michigan State Medical Society reaffirms its determination to halt the socialization of our free economy and pledges its wholehearted support to the United Nations in resisting Communistic aggression in Korea and elsewhere and urges the full collaboration of doctors of medicine with the Armed Forces of the United States.

The change in the resolution is in regard to resisting Communistic aggression in Korea. We have added, "and elsewhere," and also the word, "urges," so that it reads: ". . . and urges the full collaboration of doctors of medicine," and so forth, to slightly clarify the original resolution.

I move the adoption of this recommendation of the committee.

K. B. BABCOCK, M.D. (Wayne): I second it.

Motion carried.

XIV—f. 3. Urging Development of Simplified Insurance Reporting Form

G. T. MCKEAN, M.D. (Wayne): The committee recommends to the House of Delegates the adoption of the resolution. With the permission of the House of Delegates I will read only the Resolved part of the resolution:

RESOLVED, That the Grand Traverse-Leelanau-Benzie County Medical Society request the Michigan State Medical Society to develop a simplified reporting form which could be used by all insurance companies doing business in Michigan; and

RESOLVED further, That in those instances in which an insurance company insists on a special long complicated form, our membership shall be privileged to make a reasonable charge direct to the company for the completion of such forms.

I move the adoption of the recommendation of the committee.

M. A. DARLING, M.D. (Wayne): I second it.

Motion carried.

XIV—f. 4. Study of Nursing Needs

G. T. MCKEAN, M.D. (Wayne): The Reference Committee on Resolutions recommends the approval of the resolution in principle, but with a change of wording, as follows:

WHEREAS it is a recognized fact that there are insufficient nursing services available for public needs; and

WHEREAS present programs for the training of nurses have developed which do not fill these needs: Therefore be it

RESOLVED, That further efforts be made to ascertain the public needs in regard to nursing services and to develop programs to provide for such services.

May I say that the spirit of the resolution was not changed in any respect. It is simply a matter of changing words. I move the adoption of this recommendation.

F. A. WEISER, M.D. (Wayne): I second the motion.

Motion carried.

THE SPEAKER: Since there is a further report to come from the reference committee we won't ask for a motion now on the committee report as a whole.

XIV—g. REFERENCE COMMITTEE ON SPECIAL MEMBERSHIPS

XIV—g. 1. Emeritus Membership

D. H. KAUMP, M.D. (Wayne): The Reference Committee on Special Memberships would like to certify the following names for **Emeritus Membership:** G R. Pray, M.D., Jackson; L. L. Stewart, M.D., Jackson; James Henry, M.D., Grand Rapids; E. H. Campbell, M.D., Newberry; F. A. Watts, M.D., Owosso; Bruce Anderson, M.D., Detroit; E. O. Sage, M.D., Detroit; W. J. Stapleton, Jr., M.D., Detroit; C. A. Fettig, M.D., Detroit; L. K. Slote, M.D., Constantine; G. A. Conrad, M.D., Sault Ste. Marie.

D. H. KAUMP, M.D. (Wayne): I move the adoption of this portion of the report.

J. E. LOFSTROM, M.D. (Wayne): I second it.

Motion carried.

XIV—g. 2. Life Membership

D. H. KAUMP, M.D. (Wayne): The Reference Committee on Special Memberships has certified the following members for **Life Membership:** Wilfrid Haughey, M.D., Battle Creek; M. R. Sutton, M.D., Flint; F. L. Covert, M.D., Flint; A. J. Reynolds, M.D., Flint; D. C. Smith, M.D., Flint; E. G. Bellinger, M.D., Lansing; F. M. Huntley, M.D., Lansing; Ferdinand Cox, M.D., Jackson; W. H. Enders, M.D., Jackson; G. C. Hicks, M.D., Jackson; A. J. Baker, M.D., Grand Rapids; F. A. Boet, M.D., Grand Rapids; S. W. Thieme, M.D., Ravenna; W. C. Swartout, M.D., Muskegon; John Sundwall, M.D., Ann Arbor; C. D. Camp, M.D., Ann Arbor; Mark Marshall, M.D., Ann Arbor; Cornelius Carey, M.D., Detroit; J. C. Dodds, M.D., Detroit; B. U. Estabrook, M.D., Detroit; G. A. Kamperman, M.D., Detroit; E. G. Martin, M.D., Detroit, R. W. Hodges, M.D., Atlanta and Isaiah Sicotte, M.D, Michigamme.

D. H. KAUMP, M.D. (Wayne): I move the adoption of this portion of the report on Life Memberships.

E. B. MILLER, M.D. (Manistee): I second it.

Motion carried.

D. H. KAUMP, M.D. (Wayne): Four members of the State Society were recommended for Life Memberships. Their period of membership in the State Society varies from thirty to thirty-three years of paying dues. However, in no one of these four instances have twenty-five consecutive years elapsed. As a consequence, I would like to move that the names of these four men be held over until after the action on the change in the By-laws is taken tomorrow.

THE SPEAKER: Do you all understand what the request is? There is a proposed change in the By-laws which would make it possible for these men to be so recognized. The motion is that the names be held over until that action is taken.

D. H. KAUMP, M.D. (Wayne): That is correct.

E. D. KING, M.D. (Wayne): I second the motion.

Motion carried.

XIV—g. 3. Associate Membership

D. H. KAUMP, M.D. (Wayne): The Committee on Special Memberships noted that the following members are certified for Associate Membership: W. A. Southwick, M.D., Springport; J. T. Jiroch, M.D. Muskegon; L. W. Hayes, M.D., Grand Rapids; Stuart Bergsma, M.D., Grand Rapids; and the following from Ann Arbor: R. C. Barlow, M.D., R. C. Bates, M.D.. M. F. Bryant, Jr., M.D., Peter Buhrman, M.D., J. L. Caldwell, M.D., C. R. Calley, M.D., F. P. Campbell, M.D., G. B. Carver, M.D., J. S. Chambers, Jr., M.D., J. W. Clay, M.D., C. C. Congdon, M.D., W. T. Couter, M.D., J. C. Crenshaw, M.D., C. R. Denton, M.D., J. H. DeTar, M.D., R. P. Dobbie, Jr., M.D., R. M. Edwards, M.D., Philip Erlich, M.D., T. N. Evans, M.D., S. S. Fajans, M.D., S. B. Feinberg, M.D., M. M. Figley, M.D., G. R. Forrer, M.D., W. W. Glas, M.D., S. M. Gould, Jr., M.D., C. B. Hall, M.D., H. R. Hume, Jr., M.D., J. S. Jacob, M. D., H. T. Johnson, M.D., W. R. Johnson, Jr., M.D., E. W. Johnston, M.D., W. J. Kenfield, M.D., J. S. Krieger, M.D., W. T. Kruse, M.D., A. E. Lamberts, M.D., H. B. Latourette, M.D., J. B. Ludwig, M.D., H. D. Lueken, M.D., J. A. McHale, M.D., J. F. MacGregor, M.D., K. R. Magee, M.D., J. E. Magielski, M.D., G. L. Neligh, M.D., R. B. Neligh, M.D., M. C. Nelson, M.D., J. E. Orebaugh, M.D., D. C. Overy, M.D., G. S. Pulford, M.D., D. K. Ray, M.D., T. G. Reed, M.D., R. M. Rees, M.D., R. E. Reichert, Jr., M.D., R. J. Rowe, M.D., W. H. Ruchie, M.D., W. S. Smith, M.D., O. A. Steinnon, M.D., R. L. Thirlby, M.D., R. F. Thompson, M.D., W. H. Thompson, M.D., Paul Van Portfleit, M.D., C. H. Ward, M.D., C. E. Wheeler, M.D., W. S. Wille, M.D., C. M. Wilson, M.D., F. B. Zaugg, M.D., S. G. Zawacki, M.D.

D. H. KAUMP, M.D. (Wayne): Dr. Steward of Grand Rapids has become a medical missionary and wishes to transfer to some membership other than Active Membership. There is some question on this because there is no category in the membership which will allow for such an activity. However, we felt that it was a justifiable activity and that we were justified in transferring this man from Active to Associate Membership.

In addition to these names, there were a number of hospital residents' names submitted, one from Grand Rapids and a large number from Ann Arbor. I will not read those names, with your permission.

I move the adoption of this portion of the report.

R. W. TEED, M.D. (Washtenaw): I second it.

Motion carried.

XIV—g. 4. Retired Membership

D. H. KAUMP, M.D. (Wayne): The Committee on Special Memberships recommends for Retired Membership the following persons: T. G. Yeomans, M.D., St. Joseph; E. M. McCoy, M.D., Grand Ledge; Wm. Scholten, M.D., Kalamazoo; C. L. Grant, M.D., Manistee; W. S. Ferguson, M.D., Grand Rapids; L. D. Harrison, M.D., Flint; E. M. Ling, M.D., Spring Lake; A. R. Ernst, M.D., Saginaw; F. C. Bandy, M.D., Sault Ste. Marie.

D. H. KAUMP, M.D. (Wayne): I move the adoption of this portion of the report.

R. W. TEED, M.D. (Washtenaw): I second it.

Motion carried.

D. H. KAUMP, M.D. (Wayne): In addition there is one man who has been an active member for twenty-seven consecutive years. However, his 1950 dues have not been paid. If the change in the By-laws is passed tomorrow he will be eligible for Retired Membership. Therefore, I would like to move that we table the application of this one individual for Retired Membership and reconsider it tomorrow after the action on that amendment is taken.

M. A. DARLING, M.D. (Wayne): I second it.

Motion carried.

XIV—g. 5. Honorary Membership

D. H. KAUMP, M.D. (Wayne): The Committee on Special Memberships certifies for Honorary Membership the following two individuals: C. E. Tompkins, M.D., Benton Harbor, and C. E. Kahlke, M. D., Benton Harbor.

D. H. KAUMP, M.D. (Wayne): I move that the names of these individuals be certified for Honorary membership.

C. R. GATLEY, M.D. (Oakland): I second it.

Motion carried.

D. H. KAUMP, M.D. (Wayne): I move that the entire report be accepted.

E. D. KING, M.D. (Wayne): I second it.

Motion carried.

XIV—h. REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

XIV—h. 1. Urging Increase in Number of Medical Graduates

L. T. HENDERSON, M.D. (Wayne): One is a resolution on the campaign to increase the number of graduates from the Michigan medical schools. The committee as a whole approves this resolution and moves its adoption.

THE SPEAKER: Do you wish the resolution part read?

L. T. HENDERSON, M.D. (Wayne): I will read that part.

RESOLVED, That the Michigan State Medical Society continue and increase its efforts to gain further funds from the Michigan legislature and from the people of the State of Michigan, by concentrated drives and through contacts on a permanent basis for contributions, to the end that, (a) adequate facilities (school buildings) are supplied the two medical schools in Michigan, and (b) necessary additions to the faculty of these two Grade A schools of Michigan are made by routinely training a requisite per cent of each medical school class to become teachers; and be it

RESOLVED further, That the Michigan State Medical Society offer its co-operation to the presidents and medical deans of the University of Michigan and the Wayne University for the development of an aggressive and early campaign to secure from the State of Michigan and from alumni and other citizens who are interested in better health, funds necessary to enlarge medical facilities and faculties in this state to the end that the resulting increase in the number of medical graduates from the University of Michigan and Wayne University is sufficient to continue to give adequate and good quality medical care to the people of this state.

The committee approves this resolution, and moves its adoption.

J. E. LOFSTROM, M.D. (Wayne): I second it.

Motion carried.

XIV—h. 2. More Funds for Wayne Medical School

L. T. HENDERSON, M.D. (Wayne): We have a resolution from Wayne County, presented by Dr. Babcock. I will read that.

WHEREAS the present world situation appears to demand a lasting increase in the Armed Forces of the United States and consequently an increased need for medical personnel for an unpredictable length of time; and

WHEREAS there already exists some shortage of physicians not only for the Armed Forces but also for civilian needs; and

WHEREAS attempts to increase the educational facilities of Wayne University Medical School have fallen far short of the reasonable goals in spite of the fact that there is a wealth of unused clinical material in Wayne County; and

WHEREAS funds for the maintenance of such medical

educational facilities as are already provided are barely adequate to furnish a minimum of teaching and research personnel: Therefore be it

RESOLVED, That The Council of the Michigan State Medical Society direct suitable efforts toward securing further funds from the State of Michigan for the maintenance of the Wayne University Medical School, the second and only other medical school in the state.

The committee approves this resolution and moves its adoption.

F. A. WEISER, M.D. (Wayne): I second it.

Motion carried.

XIV—h. 3. Recommending Change in Coroner System

L. T. HENDERSON, M.D. (Wayne): The next resolution has to do with the duties of the coroner. I will read the resolution part.

RESOLVED, That the Michigan State Medical Society initiate action in attempting to legislate a change in our present coroner system to effect the abolishment of the county coroner system and the adoption of a system of appointed medical examiners who are qualified doctors of medicine.

The committee approves the resolution and moves its adoption.

R. A. SPRINGER, M.D. (St. Joseph): I second it.

Motion carried.

XIV—h. 4. Requesting Report of P.A. 59 of 1937

L. T. HENDERSON, M.D. (Wayne): The next resolution has to do with the basic science law.

THE SPEAKER: Since there is so much interest in this, it perhaps had better be read.

L. T. HENDERSON, M.D. (Wayne): I will read the entire resolution, then.

WHEREAS the basic science law was enacted by the legislature in 1937 as Public Act No. 59 after many years of study by the Michigan State Medical Society; and

WHEREAS the original concept was entirely worthy in principle, and it was hoped that it would raise the standard of the healing arts in the State of Michigan; and, however,

WHEREAS the experience of the past 13 years has demonstrated that the original concept has not been accomplished but rather the reverse, and in fact the citizens of Michigan have been deprived of the services of many well qualified physicians; and further

WHEREAS this has resulted from two particular effects of this law: (1) It has discouraged highly trained physicians from undertaking examinations in courses of study in which they qualified years previously; and (2) it has discouraged continued study and training in the institutions of this state by young men in view of lack of licensure and the necessity of additional examinations in subjects in which they themselves have already qualified and thereby imperiled the entire resident training program of the hospitals throughout the state; and

WHEREAS there have been manifold other objections to the practical application of this law: Therefore be it

RESOLVED, That this House of Delegates goes on record as favoring repeal of the Public Act No. 59 of the regular session of the legislature of the State of Michigan, 1937; and be it

RESOLVED further, That this House instruct The Council and the officers of the Michigan State Medical Society to sponsor through its legislative committee the necessary legislation to accomplish repeal of the above-named act.

The majority of the committee have approved this resolution. I move its acceptance.

H. F. DIBBLE, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion?

F. D. JOHNSON, M.D. (Genesee): I would like to hear from Dr. Christian, the man who followed the legislation and knows the thinking on it. I think he is quite capable of telling us all about it.

L. G. CHRISTIAN, M.D. (Ingham): I first wanted to correct Dr. Donaldson. He said I was in favor of repeal. I introduced the resolution this morning, as you remember, at the insistence of the County Medical Society. I am not in favor of the repeal of this law because the conception of it was right. I am in favor of changing the law, if possible. Whether that is a practical thing or not I do not know. I still believe in the basic principles of basic science. I think the law has not worked properly, however, and I would like to see it amended. That is my personal opinion. My County Society unanimously instructed me to introduce this resolution. Therefore I will go along at the insistence of my County Society for repeal. However, my own personal opinion is that we should save the application and the original conception of the law and make it workable if that is possible. I am not for repeal, personally. Have I made myself clear on that?

MEMBER: Why aren't you in favor of it?

L. G. CHRISTIAN, M.D. (Ingham): You ask why I am not in favor of repeal? Because I believe in the principle that the State Medical Society over a period of years has attempted to raise the standards of the practice of the healing arts. I still think it is a good principle and I think the law perhaps is not working properly. However, I feel there is a possibility of making it work.

J. H. SCHLEMER, M.D. (Wayne): Has the question ever been thoroughly studied by a committee of the Michigan State Medical Society?

THE SPEAKER: I am informed that Dr. Ledwidge headed a committee of six at one time to study this. That was two years ago, I believe.

J. H. SCHLEMER, M.D. (Wayne): What solution did that committee arrive at?

THE SPEAKER: I think that can be answered by our legal counsel, Mr. Herbert, who may have some remarks on that. I wonder if this is not the time to ask him to take the floor? I want the delegates to discuss this to their hearts' content, but I do not think we should come to a decision or vote without listening to Mr. Herbert.

J. H. SCHLEMER, M.D. (Wayne): I will yield the floor to him.

Mr. Herbert discussed this subject from a legal standpoint.

J. H. SCHLEMER, M.D. (Wayne): We do not turn the legislature on and off like a faucet. Once a law has been repealed, to get them to adopt another law to take its place is like pulling hen's teeth.

I move that there be a committee appointed from the Michigan State Medical Society to make a thorough study of this situation with the view of amending this law. It is much easier to amend a law than it is to repeal it and have another one enacted to take its place. This Society should study this thing thoroughly, through a committee, with the view of amending the law where necessary, to make it workable, and to place it in the hands of the physicians where it belongs. That is my motion.

R. A. SPRINGER, M.D. (St. Joseph): I second the motion.

THE SPEAKER: I cannot accept it as a motion at this time. There is a motion on the floor.

J. H. SCHLEMER, M.D. (Wayne): I did not realize there was a motion on the floor. I therefore make my motion as an amendment to the motion on the floor. As far as the committee is concerned, I think it should be a special committee, appointed by the President of the Michigan State Medical Society himself, for the sole purpose and intention of reviewing the situation, with the view of amending the law.

R. A. SPRINGER, M.D. (St. Joseph): I second it.

THE SPEAKER: Will you state the number on the committee to be appointed by the President of the Michigan State Medical Society, for referral of the question?

J. H. SCHLEMER, M.D. (Wayne): That is questionable. I don't care how many, just so they are competent to study the law and to offer amendments or to try to get amendments enacted. Leave that to the discretion of the President of the Michigan State Medical Society.

THE SPEAKER: A seven-man committee?

J. H. SCHLEMER, M.D. (Wayne): A seven-man committee would be fine.

The Speaker: The motion, as I understand it, is that there be a special committee of seven, appointed by the President of the Michigan State Medical Society, to study the revising of the Basic Science Law.

J. H. SCHLEMER: That they recommend amendments to the law and that they make a special effort, or bring back their report and let the Michigan State Medical Society make an effort in some manner, to have the legislature amend the act.

The Speaker: Further that they recommend amendments to the law and report back to the House of Delegates.

Do you want to amend this motion that the committee be instructed to report back to The Council rather than the House of Delegates?

E. S. PARMENTER, M.D. (Alpena-Alcona-Presque Isle): I would like to do so.

P. E. SUTTON, M.D. (Oakland): I second it.

THE SPEAKER: Is there any further discussion?

R. S. BREAKEY, M.D. (Ingham): Professor Henry once told me, when I got a little dogmatic, where would the Constitution of the United States be if each of the thirteen colonies had returned home, feeling individually that each had failed? The success of the country arose from a spirit of giving a little and taking a little.

I come instructed just as Dr. Christian did. I feel that the amendment is a very good one. A further program of study will do no harm. Such a committee, a special committee whose sole purpose is to evaluate the good or bad of this law, is a very good idea.

I heartily endorse this amendment. I should like, however, to suggest that the report of such a committee be made to the House of Delegates in full session next year, and not to The Council alone.

E. D. SPALDING, M.D. (Wayne): I move the previous question on the main issue and all the amendments.

C. I. OWEN, M.D. (Wayne): We should not hamstring the committee. Let the committee make what amendments it wishes, or what recommendations it desires. He will withdraw that part of the amendment that instructs the committee. I will go along with it.

J. H. SCHLEMER, M.D. (Wayne): It is not my intention to hamstring the committee at all. I will withdraw that part of my motion.

THE SPEAKER: Is it acceptable to the seconder?

R. A. SPRINGER, M.D. (St. Joseph): Yes.

THE SPEAKER: Are you ready for the question on the motion as amended, **to have a special committee report to The Council?** If you vote against that, then you throw it back to the original amendment which makes the committee report to the House of Delegates. **The first vote will be taken on whether you wish such a committee to report to The Council.**

(Call for standing vote)

THE SPEAKER: The Chair rules that the motion is lost. Now, the original referral motion was **that the special committee report to the House of Delegates.** All in favor of that say, "aye;" opposed? **That motion is carried.** That motion supersedes the original motion that was discussed, and it really defines it, so there is no need for a vote on the original motion. The question has been referred to a special committee by your vote.

L. T. HENDERSON, M.D. (Wayne): I would like to move that the report of the committee as a whole be adopted.

THE SPEAKER: The motion is that the report of the committee as a whole, as amended, be adopted. Is there a second to the motion?

The motion was severally seconded and carried.

XIV—i. REFERENCE REPORT ON EXECUTIVE SESSION

The two matters referred to this Reference Committee were reported on.

The session was adjourned at 12:05 a.m.

TUESDAY MORNING SESSION

September 19, 1950

The House of Delegates reconvened at 10:10 a.m.

THE SPEAKER: I wish to remind you gentlemen and also the Sergeant-at-Arms that we are still in Executive Session.

THE SPEAKER: The next order of business is the report of the Reference Committee on Reports of the Council, dealing with dues.

XIV—b. 6. MSMS Dues for 1951

C. K. HASLEY, M.D. (Wayne): The Reference Committee on Reports of the Council has met again and has carefully considered the question of dues. We have come to the same conclusion on the resolution of the Council, No. 6, which reads as follows:

That the annual dues of the Michigan State Medical Society be set at $50 to provide necessary appropriations for the various purposes in the work of the Michigan State Medical Society.

We have changed that to read:

The committee appreciates the tremendous work that the Michigan State Medical Society is doing and the need of additional funds for expanded activities. The committee recommends that the annual dues be set at $45 per year.

We have come to that conclusion because we feel there is a necessity for it. I would like to give you a few figures to substantiate our line of thought. You will recall that for three years the sum of money allocated to public education was approximately $30,000, so that within the three years they accumulated a sum of $100,000, which was set up as a reserve. On January 1, 1949, they had on hand this $100,000 fund which had been set up. However, due to the increased expense in carrying on the activities of the Society that particular fund was depleted, so that on January 1, 1951, they will have an estimated $54,049 left out of the $100,000. In other words, $55,000 has been taken from that fund to carry on the activities of the Society. That shows there is a need.

Another thing is that I think some of the amendments that were offered last night were due to an erroneous impression. If this dues increase to $45 is passed it will mean an increase of only $8, because the $45 absorbs the $25 special assessment. The term "special assessment" is deleted by the passage of this motion. So we will have no trouble in regard to reporting it for income tax returns.

The $8, if you break it down a little further, means between 2 and 3 cents a day. There is nobody starting out in medicine who cannot afford 2 or 3 cents a day. In other words, it is about two packages of cigarettes a month. Consequently, we feel that anyone can stand that, and there is no need of attaching any riders to this resolution.

I move the adoption of this recommendation of the committee, which is $45 dues per year.

R. S. BALLMER, M.D. (Midland): I second it.

THE SPEAKER: I think there is some discrepancy in

the figures given you. I will ask Dr. Osius to make a report.

E. A. Osius, M.D. (Wayne): Of the $25 assessment you paid, each of the succeeding years up to 1949 a certain sum was taken out and was put aside in what was known as the reserve fund. Over a period of time that amounted to roughly $100,000. That was a reserve or sheet anchor fund, so that if the pressure got to be pretty bad we could use that in certain directions. That was to be spent at the direction of The Council. A special committee in which the Finance Committee chairman sat and several other members of The Council was appointed to supervise the distribution of that particular sum of money. The rest of the money obtained from the $25 assessment was used for current public relations. It has been so used since that time.

Now, the $100,000 reserve fund has run out, as of this month, or there is only a balance of $1,000, or thereabout. The public relations money from the $25 assessment is being used right along, and at the end of this year there will be, we believe, about $50,000 balance in that particular fund.

Now, that may sound like a lot of money, but it is not. The expense of everything has gone up, plus the fact that it takes money to put that sort of thing on.

There is a budget for next year for the public relations fund of roughly $140,000, estimated. Budgets always have to be estimated high in order to come somewhere within striking distance. We hope it will be lower. However, in the $140,000 budget is an ear-marked fund of $30,000 which is to again start on a so-called reserve fund.

The reason that we ask for an increase in dues is this: It has nothing to do necessarily with the public relations end of it. That is to be handled from the $25. We have what is known as a general fund, which has to do with salaries, the salaries of the people who are in the office. Incidentally we have 15 employes in the Michigan State Medical Society now, and the salary budget is not very low, from the standpoint of total amount. It pays for postage, for printing, for telephone, telegraph, it pays for things like the Postgraduate Institute, for things like the state meeting that you are sitting at here, and so forth. The monies obtained to run the general fund come out of the dues, the $12.

We have found through the bookkeeping—which is in the hands of Bob Roney, who is a capable bookkeeper and auditor, that each year, in 1948 and 1949, we have dropped behind what we should. So by order of The Council, $5 of the $25 assessment, which was scheduled for public relations, was used to make up the so-called bookkeeping deficit in the general fund.

The way that was justified was this: These two functions, public relations and the general fund, have many inter-lacing and inter-communicating functions; it is impossible to separate one from the other. For example, the public relations group will do things for the general fund, and the general fund will do things for public relations, and so on. So in a sense they are so inter-locking that it is almost impossible to separate each individual item. We thought it was better, however, from a bookkeeping standpoint, to have these things clear and have each one in a sense carry its own share and be so specified in the books. On the other hand, we have this to combat: The increased cost, for example, of space. We have to enlarge the office space in the Olds Tower. They were practically triple-decking the desks for a while. If any of you doubt that we invite you to come up and take a good look. The salaries have had to be increased from time to time to keep pace with the average living costs, which you all know about just as well as I do. Everything else has gone up: Printing, employes, rent, light, the whole business. As you all know, in the last 10 years there has been over a 100 per cent increase in expenses of all sorts, just to stay alive, to put it bluntly and frankly.

That is the reason we have asked for an $8 increase. The general deficit, the bookkeeping deficit—understand, not an actual red deficit—has been running on the average of about $11,000 out of the general fund for a year. It was $14,000 in 1949 and $8,000 in 1948, which averages about $11,000. This year we think the deficit will be about $5,000, which may be made up in part by a small profit that The Journal sometimes makes through advertising, and so on. So generally speaking we are in pretty good shape. On the other hand, we feel we should anticipate a little bit and look ahead.

There is one other point that we feel is important from the standpoint of raising dues, which is this: We expect shortly to lose a fair number of members to the military service; if not to lose, at least not to get our quota of new men as they come out of school. That will have to be met in some way. Hence, the $8 increase will tend in some sense to cushion that. Also, we do not think for a minute that the living expenses are going to stand static, nor do you. Those are the reasons for the recommended increase in dues.

We have sent around to various other states and inquired what they were doing. We found many states have $10 and $15 dues, and some have special assessments. However, we did find that the progressive states, of which I am glad to say we are one, if not the foremost member, ran about $50. Among those states are California, Oregon, Colorado, et cetera.

I think the program the Michigan State Medical Society has put on in the last years in all directions deserves a lot of commendation. It has stood out in front in many things. Some of the things we advocated as far back as five, six and seven years ago are now being picked up by the other organizations and by the American Medical Association, and so on, are being aped. Gentlemen, there is no greater compliment than to be copied.

Now, if you wish to cut down the program, if you wish to bring it down to a different level, that is your perfect right as delegates to so instruct us. If you wish to keep up what we are doing—and I believe what we are doing is in all respects done with good intent, with possibly mistakes here and there, because after all, the Councilor is human, too; they get tired of sitting from 10:30 in the morning until 12:30 at night, not once in a while but steadily, so they might make a few mistakes here and there. They might allot a certain sum of money that you think is not of great benefit, and another man might think it is of great benefit, so in an organization of this kind you have to strike a happy medium. However, I think a good job has been done, and it is well worthwhile keeping it up. I think the request for the extra dues is not unjustified, and I believe that your confidence will not be destroyed in the handling of those funds. Thank you.

The Speaker: There is a motion before you to adopt the recommendation of the committee. Is there any other discussion?

Call for the question. Motion carried.

The By-laws Committee will please report at this time.

XIV—e. 4. By-Laws Chap. 5, Sec. 9

C. I. Owen, M.D. (Wayne): There was one subject to be reported on last evening that was misunderstood by practically everyone I talked to, about twenty-five or thirty. For that reason I am going to move a reconsideration. That is the resolution presented by Washtenaw County amending Chapter 5, Section 9. That reads as follows:

Whereas, the By-laws relating to election of members of the Michigan State Medical Society to Retired, Emeritus and Life Membership are indefinite on a certain point; and

Whereas, a member qualifying for Retired, Emeritus or Life Membership during the interval between the fall meeting of the House of Delegates and the beginning of the following fiscal year would be required to pay

dues the following year in order to maintain active membership; and

WHEREAS, such provision has already worked a hardship in the Washtenaw County Medical Society: Therefore be it

RESOLVED, That Chapter 5, Section 9 of the By-laws of the Michigan State Medical Society be amended as follows: After the words, "Annual Session of the House of Delegates," the following sentence be inserted: "Such certification shall be valid for a period of twelve calendar months, during which time the applicant shall not be required to pay dues."

E. D. SPALDING, M.D. (Wayne): In view of the fact that you cannot get anybody to move to reconsider, I will move that it be rescinded.

F. A. WEISER, M.D. (Wayne): I second the motion.

Motion carried.

THE SPEAKER: Now, Dr. Owen, your motion is in order.

C. I. OWEN, M.D. (Wayne): The recommendation of the Reference Committee on Constitution and By-laws is that this resolution not be adopted and that this amendment not be made. I so move.

B. M. HARRIS, M.D. (Washtenaw): I second it.

THE VICE SPEAKER: As I understand it now, there will be no change in the By-laws regarding this matter. That is the motion. Is there further discussion?

R. W. TEED, M.D. (Washtenaw): Do I understand that if we vote "yes" on this motion that, in effect, the resolution is defeated?

THE VICE SPEAKER: That is correct.

R. W. TEED, M.D. (Washtenaw): I would like to go back a bit and explain why this resolution was presented. I won't bore you with all the difficulties and details we have had in the Executive Council as a result of this problem. I would simply like to point out that there is an injustice in the By-laws as they are now written. If a man reaches 70 on the day after the House of Delegates closes its meeting he cannot apply for Life Membership until another year. In other words, he is being penalized, because another man who becomes 70 a week before the meeting could be certified for Life Membership and could be transferred to that rostrum.

It was our feeling that it was unjust to discriminate against the man who happened to be born after the House of Delegates meeting in favor of the man who was fortunate enough not to be born after the meeting, but before. We therefore feel this injustice should be corrected and the By-laws changed.

E. D. SPALDING, M.D. (Wayne): I am on this committee whose report you just heard. The committee is perfectly in sympathy with the fact that in individual cases injustice is done which should be corrected. However, the best method of correction is not to correct your By-laws. There are many cases where such action is taken to change a membership, in which finances are of no consideration. If you open the door by changing your By-laws you are depleting your treasury by withdrawing the dues of someone perfectly able to pay them. In the individual cases where a gross injustice is being done The Council is delighted to recognize such. All you need to do is to write the facts of such a case to The Council. The Council will be glad to make a special provision for the cancelling of dues in such a case. These cases should be considered on their individual merits and not make a blanket change in the By-laws. That is the reason the committee is quite in favor of what you specifically want to do, but they are trying to point out to you that you are not trying to do it in the wisest way.

O. K. ENGELKE, M.D. (Washtenaw): I think Dr. Spalding's philosophy is excellent. However, the practical application over the last year was just not there. This thing has been in and out of The Council just about as often as it has been in and out of the Executive Council of the Washtenaw Medical Society. We did not get to first base. We wasted an awful lot of time. I think philosophy is okay, but this philosophy is getting expensive. I would like to point out that this is not the only case; that there is another case pending before this group which will be discussed immediately following whatever action is taken on the motion, where a similar condition has arisen. Now, are we so hard up with the increase in dues that we have to ask a man who has reached 70 to kick in with his $20 to maintain the Michigan State Medical Society, and have to in effect tell him, "We're sorry, Bud, but we cannot use you"? We passed a motion just a few moments ago that should put us on a fairly sound financial footing.

I would like to point out also that the men who have reached seventy do not like to be placed on charity. They do not like to have special motions made so that they do not have to pay dues. I think there is a principle involved. I would like to know what harm there is in this thing, except the loss of a few bucks.

C. K. STROUP, M.D. (Genesee): I would like to ask a question. Is not this proposal as put up in the first place an idea to change the fiscal year? After all, we have to have a fiscal year sometime. If we did it the way Washtenaw is asking the man would get it if he became sixty-nine. I think it should be left at seventy.

O. K. ENGELKE, M.D. (Washtenaw): I don't know how the last issue was raised. Nobody said anything about changing the fiscal year. What you are in effect saying, though, is that some people have to be seventy-one.

G. T. MCKEAN, M.D. (Wayne): I am secretary of the Wayne County Medical Society. We were turned down by The Council in a similar request, when we asked that the dues be put off in 1950 in regard to someone who had turned seventy. That is particularly in answer to Dr. Spalding's comment about The Council activity on this.

E. D. SPALDING, M.D. (Wayne): Could we hear from Dr. Sladek, past president, who sat on The Council for years? I think he can talk to you on the subject.

E. F. SLADEK, M.D. (Grand Traverse-Leelanau-Benzie): This question of special memberships has been a sore spot with The Council. There have not been many, but there have been occasional instances when there has been a request that a member be admitted to one of the special categories of membership. In most cases there has been presented insufficient evidence. Very few cases have shown that it would be a hardship to pay the additional year's dues. In those cases where a definite hardship is proven by a statement by the candidate we have eliminated the payment of that extra year's dues and have granted the membership. You have to present sufficient evidence for us to make that decision. However, we do consider each case individually.

THE VICE SPEAKER: The motion on the floor is, in effect, that there be no change in the By-laws regarding this matter.

Call for the question. Motion carried.

XIV—c. 5. Creating Section on Gastroenterology and Proctology

C. I. OWEN, M.D. (Wayne): The next resolution was presented by Dr. Sladek, last evening, and was referred to this committee:

WHEREAS, there is an ever-increasing interest in diseases of the anus, rectum and colon; and

WHEREAS, there are more doctors of medicine devoting their efforts in all or part to these conditions; and

WHEREAS, a section in the Scientific Assembly of the Michigan State Medical Society on the subject of rectal and colon diseases could contribute greatly to the scientific program of the State Society and its Postgraduate Institute; and

WHEREAS, there is now a Michigan Proctologic Society: Therefore be it

RESOLVED, That the House of Delegates of the Michi-

gan State Medical Society approve the development of a section on Proctology.

The committee discussed that this morning. Here are a few facts: There is a Board of Proctology. There are forty-seven doctors in Michigan listed in the American Medical Association as interested in proctology. There are thirty-two members who claim they are practicing it exclusively. The committee did not feel that this was a sufficient number to warrant the establishment of a section on proctology. We do recognize, however, that the American Medical Association has a section on gastroenterology and proctology. Therefore, the committee amended the resolution to read as follows:

That the House of Delegates of the Michigan State Medical Society approve the development of a section on gastroenterology and proctology.

There is no place in the Constitution or By-laws that sets up sections. There is simply a Scientific Assembly provided for. The Scientific Assembly is apparently autonomous, or at least under The Council. There is no way of knowing from the Constitution and By-laws. However, the committee does approve of this resolution and recommends its adoption as amended. I so move.

E. D. SPALDING, M.D. (Wayne): I second it.

Motion carried.

XIV—c. 3. By-Laws Ch. 5—Sec. 7, Re Life Membership

C. I. OWEN, M.D. (Wayne): There are two proposed amendments to the By-laws, read last night. They have to be read again this morning and acted on this morning, last night having been the first time of presentation. The first amends the By-laws on the question of Life Membership, as follows: Chapter 5, Section 7, is changed to delete the word "consecutive" between the words "twenty-five" and "years." Previously, in order to be a Life Member a person must have been a member for twenty-five years consecutively. It is recommended that the word "consecutive" be dropped because of persons who for any number of reasons may have dropped their membership for a year or two. The county society may have been inactive, or perhaps it was during the depression, or any number of reasons.

I move the adoption of this recommendation.

R. S. BREAKEY, M.D. (Ingham): I second it.

Motion carried.

XIV—e. 2. By-Laws Ch. 8—Sec. 10—Par. g—Re-election of Councilors

C. I. OWEN, M.D. (Wayne): There was an amendment to the By-laws in regard to a special committee to study Councilor Districts. This amendment was to Chapter 8, Section 10, paragraph g, which occurs on page 140 of the handbook. The amendment read last evening is as follows: That two sentences be added to this paragraph, the first sentence as follows:

Component county societies of Councilor Districts shall be notified in writing by the Secretary of the State Society 60 days in advance of the annual meeting when a Councilor is to be elected from their District at the expiration of the usual term.

At the present time Councilors are chosen for five years. The Districts are supposed to recommend the election of the Councilor. Many times they neglect to do anything about it because it has not been called to their attention.

The second sentence is more important:

If a vacancy in The Council occurs during an annual meeting of the Michigan State Medical Society the delegates of the component county societies will be given time in which to conduct a caucus in order to consider nomination(s) for the vacancy.

The reason for this sentence is that occasionally a Councilor is elected to a new position when there is an election of officers. That requires a new Councilor for that District. This makes it mandatory for the group of county delegates to withdraw and consider the recommendations for a new Councilor, rather than one spontaneously being recommended from the floor.

R. V. WALKER, M.D. (Wayne): I second it.

Motion carried.

C. I. OWEN, M.D. (Wayne): I move the report of the committee as a whole be accepted.

J. J. LIGHTBODY, M.D. (Wayne): I second it.

Motion carried.

XIV—j. 1. Reference Committee on Medical Service and Prepayment Insurance. Reimbursement of Attending Physician by MMS

R. L. NOVY, M.D. (Wayne): There was only one item that came before the committee. The committee met with the men interested in the proposition, and the committee made their decision. I will read the resolution. (See Page 1476.)

R. L. NOVY, M.D. (Wayne): It was the unanimous feeling of the committee that this was nothing more than an attempt to legitimatize fee splitting. It is unethical, as the Whereases indicate. It is unethical for the consultant to split fees. It was the feeling of the committee, and admitted by the proponents of this, that the problem is primarily an ethical one and should come up when fee splitting becomes ethical. Then the insurance problem can be taken up and it can be accomplished if the ethics of fee splitting are accepted in this Society.

It is therefore the recommendation of this committee that this be disapproved. I so move.

T. P. WICKCLIFFE, M.D. (Houghton-Baraga-Keeweenaw): I second it.

THE SPEAKER: Is there any discussion?

J. R. RODGER, M.D. (Northern Michigan Medical Society): The situation that was apparently apparent when the resolution was presented has in part been solved by the decision of the Executive Office of the College of Surgeons, even though I am sure the decision is unknown to about 95 per cent of the men of the College. In our section of the country one of the surgeons who never split fees with anyone was perturbed by a question put to him by a younger colleague who very frequently referred cases to him. He went along and assisted at the operation. In the usual way he presented a separate fee. However, he was stumped when it came to the question of what to do when a patient paid with one check, either from a government agency or Blue Cross. That question was presented to the Executive Secretary of the College of Surgeons.

In a ruling given by letter to this particular member of the College a term was, I think, coined. It was called an adjudicated fee. In the letter it was stated to the surgeon that a member of the College paid by one check from a government agency or from an insurance plan could pay to an assistant who referred the case and who actually assisted a fee which was commensurate with his service, which would be called an adjudicated fee and which, in the opinion of the Executive Secretary of the College of Surgeons was not fee splitting. That may be a solution to the problem. That has been done for two years in this particular case.

Motion carried.

X—l. INFORMATION TO PUBLIC ON ATOMIC DISASTER

B. M. HARRIS, M.D. (Washtenaw): I would like to present this resolution:

WHEREAS, the Emergency Medical Service Committee, the Committee on Atomic and Allied Procedures and other committees of the Michigan State Medical Society are working on problems affecting the health and welfare of the people in respect to civilian defense and in connection with the protection of life in the event of an atomic attack; and

WHEREAS, the information developed by these com-

mittees can be of maximum service to the people only if it is disseminated to the public in proper fashion; and

WHEREAS, lay publications recently have been devoting extensive space to this problem the medical profession has been planning for the people's medical care protection for the past two years; and

WHEREAS, the Public Relations Department of the Michigan State Medical Society has the means whereby this information can be broadcast: Therefore be it

RESOLVED, That the Public Relations Committee of the Michigan State Medical Society be instructed to devote a portion of its efforts to the education of the public in respect to matters of health and medical care having to do with the dangers posed by atomic attack.

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

X—m. MOTION RE PRINTED REPORTS OF COMMISSION ON HEALING ARTS

R. S. BREAKEY, M.D. (Ingham): I should welcome the opinion of the other members of the House, to clarify the question. **I move that each delegate be permitted to retain his copy of the Report of the Commission on Healing Arts, to use at his best discretion in his own represented area.**

F. A. WEISER, M.D. (Wayne): I second it.

Motion carried.

XIV—f. 5. Supplementary X-Ray and Electrocardiograhic Service Certificate of MMS

G. T. MCKEAN, M.D. (Wayne): There are two resolutions dealing with the same matter which were referred to the Resolutions Committee. For complete understanding, it will be necessary for me to read the substance of the two resolutions.

WHEREAS, the American Medical Association through its Bureau of Medical Economics, its Judicial Council and the House of Delegates has reaffirmed the principle that hospital service plans should exclude all medical services, and the contract provisions of such plans shall be limited exclusively to hospital services, (and so there will be no misunderstanding the House of Delegates of the American Medical Association has stated that, "If hospital service is limited to include only hospital room accommodations, such as bed, board, operating room, medicines, surgical dressings and general nursing care, the distinction between hospital service and medical service will be clear"): and

WHEREAS, the House of Delegates of the American Medical Association has stated that the practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine; and

WHEREAS, the House of Delegates of the American Medical Association has recommended that Blue Shield and Blue Cross be requested to co-operate to the extent of writing all contracts in such a manner that Blue Shield will cover insurable medical services only and Blue Cross will cover insurable hospital services only; and

WHEREAS, Michigan Medical Service now issues an X-ray and electrocardiographic supplemental certificate only to a holder of a Michigan Hospital Service certificate; and

WHEREAS, the supplemental certificate is reinsured with Michigan Hospital Service in accordance with an agreement between Michigan Hospital Service and Michigan Medical Service, this agreement being an act of questionable legality under the enabling act, and constitutes a subterfuge by which medical service is furnished by a hospital service contract; and

WHEREAS, this subterfuge encourages the corporate practice of medicine by hospitals; and

WHEREAS, this process is contrary to the letter and the spirit of the actions of the House of Delegates of the American Medical Association: Therefore be it

RESOLVED, That the Michigan State Medical Society condemns such acts and subterfuges and instructs its delegates who are members of the Michigan Medical Service to cause such practices to be discontinued by Michigan Medical Service.

The substitute resolution presented last evening to the House reads as follows:

WHEREAS, Michigan Medical Service now issues a supplementary x-ray and electrocardiographic service certificate only to holders of a Michigan Hospital Certificate, which, through a series of bookkeeping steps in effect places the Michigan Hospital Service in the position of insuring a service which the American Medical Association has just reaffirmed is a medical service; and

WHEREAS, the American Medical Association has specifically stated that hospital service contracts should cover only hospital services as published in the JAMA, July 22, 1950, page 1091: Therefore be it

RESOLVED, That the Michigan State Medical Society instruct its delegates who are members of Michigan Medical Service to take neccessary steps to have Michigan Medical Service desist as a party to a practice contrary to the policy of the American Medical Association.

The Resolutions Committee considered at length the resolution presented to the House of Delegates by Dr. F. D. Johnson of Flint and the substitute resolution presented by Dr. C. W. Stroup dealing with the supplemental certificate of Michigan Medical Service allowing complete in-hospital coverage of the costs of x-ray and electrocardiograms. Extensive assistance was given by Dr. Robert Novy, four delegates from Genesee County offered views on these resolutions, and opinions dissenting from those of the Genesee group were presented personally by three radiologists, and, through data offered by the Michigan Medical Service office, from another group of radiologists.

It is the unanimous opinion of the Resolutions Committee that portions of the original resolution had to do with legal matters which did not come within the scope of action of the committee or the House of Delegates.

Your committee cannot accept the views that there is any intention in this contract of Michigan Medical Service to promote the usurpation of medical practice by hospitals, nor that the supplementary service certificate works to this end.

It is, therefore, the recommendation of your committee that these resolutions be disapproved. I so move.

J. W. LOGIE, M.D. (Kent): I second the motion.

THE SPEAKER: Is there any discussion?

C. W. COLWELL, M.D. (Genesee): I am very sure I represent my constituents and I don't have to go back for instruction on this. We were enlightened quite a lot this morning in the presence of the Reference Committee when we were told that pressure had been put on the Michigan Medical Service by a large company, a steel company, I believe, to offer this service. We were also enlightened—at least, I was—as to how much the hospitals are in the practice of medicine. Dr. Novy stated that the checks for Michigan Medical Service were made out to the roentgenologist directly. Then it was explained very carefully how the roentgenologist signed the checks over to the hospital and the hospital cashier received the money, indirectly, shall we say, from the Michigan Medical Service. We believe that is a type of hospital practice of medicine.

If a large company, such as this steel company, can put pressure on to get unlimited x-ray service, which is some type of practice of medicine by the hospital, what is to prevent the same company next year from asking for full coverage for obstetrical service, for instance, and the hospital offering an obstetrician who will also sign the checks over to the hospital, which will be the practice of medicine.

We in Genesee County are trying to be constructive and trying to keep the practice of medicine in the doctors' offices. This is just one more way in which the practice of the doctors can be taken away from them.

THE SPEAKER: Is there any other discussion?

J. H. SCHLEMER, M.D. (Wayne): I think we should be very careful with the resolutions that have been presented. It is true that it is illegal for a corporation to practice medicine. We have in this city a very large hospital that is a corporation, and it is practicing medicine. However, I would hate to attempt to go into court to stop them, with the terrific amount of money they have behind them and the terrific array of legal talent that they could hire. What about our University Hospital?

E. D. SPALDING, M.D. (Wayne): And Henry Ford Hospital.

J. H. SCHLEMER, M.D. (Wayne): Well, I have Henry Ford Hospital in mind. I didn't want to mention that hospital specifically, but since it has been brought out, both those hospitals are practicing medicine. Are we going to stop these hospitals from practicing medicine? I would hate to undertake it. So let us be very careful with these resolutions.

C. W. COLWELL, M.D. (Genesee): I have one more comment. Before the Reference Committee this morning—I believe I am correct and I will gladly be corrected if I am wrong—a roentgenologist who spoke in favor of the resolution stated that this profession had been completely sold down the river. I believe Dr. Novy said they had been sold down the river. Still, they are willing to keep going down the same river. Here is a time when we could at least partially put a stop-gap in this thing and not sell any more of us down the river.

J. H. SCHLEMER, M.D. (Wayne): Then let's do it cautiously!

C. K. STROUP, M.D. (Genesee): There is one other point which I think should be emphasized: that some of the policies are issued by the Michigan Medical Service and Michigan Hospital Service before they are ever brought up and discussed before the Society. I feel sure that had the prepayment of one of the policies by the Michigan Medical Service been brought up on the floor we today would not be paying a large per cent of Michigan Medical Service money to this cause. The same thing applies somewhat to this policy; not to that extent, but they are presented to us as matters of fact. We have to save face and go along with the proposal brought up by the service. I think it is very unfortunate that the proposal had to come from Genesee County. I think if some other county had presented it, it would have been received with much more approbation.

THE SPEAKER: I must make a remark in defense of the preparation of policies by a prime corporation, of which you are a part. Such major questions as you will consider this afternoon come before you, not as delegates, but as delegate members of the Michigan Medical Service. The Michigan State Medical Society cannot dictate the insurance policies of a corporation you put on its feet and then gave the go-ahead to, but it will continue to have considerable control by its medical membership on the Board of Directors.

Are you ready for the question?

J. E. LOFSTROM, M.D. (Wayne): Since mention has been made of the remarks of a roentgenologist at the meeting this morning I should say a word, inasmuch as the remarks came from me. I was there; I attended the meeting. I attended also a meeting of a group of radiologists, which comprised representatives on a rather state-wide basis last February when this was presented. At that time it was a package that had already been accepted, been adopted by the Board of Directors, or the governing body of the Michigan Medical Service. We were more or less helpless in that regard. I certainly subscribe to the attitude of the group from Genesee County in presenting this motion of objection. I had planned to bring that up on the floor this afternoon.

The consideration of the group at that time, after having that adequately explained to them—and I feel I speak for a fairly representative group of radiologists in the state—is that we do not want to do anything to sabotage the efforts of the medical profession in expanding the voluntary insurance plan, whether it be strictly hospital or whether it be combined medical service and hospital. It was our feeling that if this were opposed completely and ruled out that the same would hold as far as the present medical and surgical benefits were concerned. They could not be offered as a package to the consumer. We do not feel that we have been placed in any greater jeopardy in this maneuver than the remainder of the profession in accepting medical-surgical plans. The Michigan Medical Service has been very careful to maintain integrity in this insurance plan, that this is a medical benefit. In Ohio, Pennsylvania and other states it is written strictly as a hospital benefit. We unalterably oppose that. Here it is provided as a strictly medical benefit, and it is so written and so expressed in the rider.

Therefore, we agreed and lent our support to the representatives of the Michigan Medical Service in this particular instance.

I certainly wish to commend the men of Genesee County in their opposition to the fact that the Board of Directors of the Michigan Medical Service proceed without adequate representative opinion being offered by effective groups. However, I think that can be taken up subsequently.

I think I speak for the majority of radiologists, certainly in this area, when I say they have accepted and are in favor of this present rider.

THE SPEAKER: Is there any other discussion?

G. T. MCKEAN, M.D. (Wayne): I might try to say a few of the things Dr. Novy said to us. He emphasized that this was a payment direct to the radiologists. The radiologists had a right to do anything they wished with the check. Michigan Hospital Service played a role only in two places. One was that the certificate was sold only along with the Michigan Hospital Certificate. The other, that the Michigan Hospital Service was willing to take some financial responsibility in backing up the program. Michigan Medical Service was taking no orders from Michigan Hospital Service in that matter.

Call for the question. Motion carried.

G. T. MCKEAN, M.D. (Wayne): I move the report of the committee as a whole be approved.

H. H. RIECKER, M.D. (Washtenaw): I second it.

Motion carried.

THE SPEAKER: The Chair declares this meeting recessed until tonight at 8:00 p.m.

The session thereupon adjourned at 12:30 p.m.

TUESDAY EVENING SESSION

September 19, 1950

The House of Delegates reconvened at 8:20 p.m.

THE SPEAKER: It is an unusual honor in having the President of the American Medical Association with us. I will turn the introduction of our speaker over to our President-Elect, Dr. Umphrey. He will assume the chair from here on.

XV—Remarks of E. L. Henderson, M.D., President AMA

PRESIDENT-ELECT C. E. UMPHREY: Tonight it is my pleasure to introduce a man who started out as many of the rest of us started out, on the farm. He is a graduate of the University of Louisville Medical School, 1909. He is a distinguished surgeon. He belongs to

the Kentucky State Medical Association and the Jefferson County Medical Society.

Dr. Henderson has been active in the American Medical Association for many years. He was elected to the House of Delegates policy-making body of the American Medical Association in 1937. Two years later he became a member of the Board of Trustees, and was elected as its chairman in 1947.

Dr. Henderson is Director of the Crippled Children's Hospital and a staff member of the Kentucky Baptist Hospital and St. Joseph's Infirmary. He served as major in World War I; was a lieutenant colonel in the Medical Reserve Corps for many years. In World War II, he was chairman of the Fifth Service Command Committee on Procurement and Assignment Service for physicians and dentists. Since 1942 he has been a special surgical consultant to the Air Surgeon's office. He has been active in world medicine.

Tonight it gives me a great deal of plesure to introduce to you the President of the American Medical Association and President-Elect of the World Medical Organization, Dr. Henderson.

(The members arose and applauded; Dr. Henderson thereupon presented his prepared paper.)

PRESIDENT-ELECT UMPHREY: Thank you, Dr. Henderson, for the excellent talk. We in Michigan wish to convey to you this message: that the medical men of Michigan not only support the program of the American Medical Association, but if there is any personal service that we can render to you while in office we stand ready to render that service.

I will now turn the chair back to Dr. Baker.

THE SPEAKER: Gentlemen, it is our privilege now to listen to Dr. Henderson off the air. He will make a few remarks to us personally.

E. L. HENDERSON, M.D.: My remarks are for doctors generally. I might make some remarks here in the presence of doctors that I would not like to make over the radio. For that reason, I reserved some remarks until after I talked on the radio.

The other day, a memorandum came across my desk from one of the leading dentists of the country. He made the remark in a rather critical way that in my talks before groups throughout the country I failed to include the dentists. I do not think we have any dentists here this evening, but when I talk about doctors I include physicians and dentists. The dentists are somewhat sensitive. Sometimes they are critical if you refer to "doctors and dentists." I always try to refer to "physicians and dentists." When I talk of the medical profession I naturally include the dentists. When I talk of our fight against socialized medicine and socialization in general I speak of all of our allied profession, because we need all of our allied profession, and they are grouped with us and should fight right along by our side. The druggists throughout our country as well as the dentists are doing a splendid job; they are co-operating with us 100 per cent in our fight against compulsory health insurance. I say they are fighting and co-operating 100 per cent. I mean in so far as the doctors are concerned. You must remember that we have a certain group of doctors in this country who are not co-operating 100 per cent.

I have here a little pamphlet that I would call to your attention. Probably some of you have seen it, and also this other pamphlet. They look just the same from where you are sitting. They are just the same, except for the frontispiece. For instance, this pamphlet was put out by the Committee for the Nation's Health, known as the National Health Insurance Handbook, "A Practical Guide for Leaders," Committee for the Nation's Health, 1416 F Street, N.W., Washington, D. C.

Here is the same booklet, with the title, "Administration's Health Program," Training Kit for Leaders, Democratic National Committee, 1218 Street, N.W., Washington, D. C. That booklet has been sent out all over the country to Democrat workers, throughout the states and counties and precincts of this country.

Now, gentlemen, I am not a partisan politician. The truth is that I have been registered as a Democrat as long as I have been old enough to vote. The truth also is that I am not a Social Democrat. We certainly have plenty of them in this country. If we are to fight socialism we have got to fight the organizations that are getting out and fighting us. Any other course would be a tragic betrayal, not of our profession but of the American people. I urge all of you to get out and fight for the men who are willing to stand up for the American way of life, for the American principle, not only in medicine but in all stems of American life.

American medicine is stronger today than ever in the history of American medicine. We have more unity in the medical profession today than ever in the history of our profession. That has required a lot of work; it has necessitated overcoming many problems. However, you do not hear today the bickering in the medical profession that you heard a few years ago.

The doctors of this country can control any election if they just get out and work at it. I think the results of the election in Florida and also in North Carolina thoroughly demonstrate that. In Florida a great many people thought it would be impossible for them to defeat Senator Pepper, but he was defeated. The doctors and their wives and their office help and the allied professions, the dentists and their wives and the pharmacists, all of them went in together, and don't forget the Women's Auxiliary. They did a wonderful job down there, and they can do a wonderful job anywhere they are called upon to do a job, if you let them do it. If we just get out and do the job we can control the elections in this country, and that is the only way we are going to be able to defeat socialism in this country.

You cannot do that as a medical organization, as a medical society, but you can do it by organizing committees of doctors in various communities, doctors in the allied professions, such as political action committees made up of physicians and the allied professions. You can get out and really work and accomplish something. In Florida they had a letter-writing campaign. All the doctors who were interested wrote letters to all their patients. The letters were prepared and signed by the doctors in their offices and sent out over their signatures. The women went out from door to door and worked during the campaign. On election day most of the doctors closed up their offices and they and their wives used their cars to get the voters out. Those are the things that must be done if we are to control elections.

As I said before, I am not talking about any party affiliation. There are good men in all the parties, but there are socialistic men in most of the parties. It is our duty not only to preserve the American way of practicing medicine, not only for the freedom of medicine, but for freedom of all Americans. (*Applause*)

THE SPEAKER: Thank you, Dr. Henderson. We appreciate your spending your time to give us these additional remarks.

I now call for any unfinished business.

XIV—g. 1. On Emeritus Membership

D. H. KAUMP, M.D. (Wayne): The Special Memberships Committee would like to certify the nomination of F. A. Watts, of Owosso, for Emeritus Membership. I so move.

The motion was severally seconded and carried.

THE SPEAKER: Are there any other supplementary reports of Reference Committees to be considered at this time?

L. T. HENDERSON, M.D. (Wayne): This is a short resolution. I will read it:

XIV—h. 5. Information to Public on Atomic Disaster

WHEREAS, the Emergency Medical Service Committee, the Committee on Atomic and Allied Procedures

and other committees of the Michigan State Medical Society are working on problems affecting the health and welfare of the people in respect to civilian defense and in connection with the protection of life in the event of an atomic attack; and

WHEREAS, the information developed by these committees can be of maximum service to the people only if it is disseminated to the public in proper fashion; and

WHEREAS, lay publications recently have been devoting extensive space to this problem the medical profession has been planning for the people's medical care protection for the past two years; and

WHEREAS, the Public Relations Committee of the Michigan State Medical Society has the means whereby this information can be broadcast: Therefore be it

RESOLVED, That the Public Relations Committee of the Michigan State Medical Society be instructed to devote a portion of its efforts to the education of the public in respect to matters of health and medical care having to do with the dangers posed by atomic attack.

The committee approves this resolution and moves its adoption.

B. M. HARRIS, M.D. (Washtenaw): I second it.

Motion carried.

XVI—Election of Officers

We are ready to proceed with the Election of Councilors. There are four Councilors listed in the Handbook, whose terms expire this year. We will first accept nominations for Councilor to the 2nd District.

XVI—a. COUNCILOR 2ND DISTRICT

H. W. WILEY, M.D. (Ingham): I am one of the representatives of the 2nd Councilor District. At a caucus held this noon, it was agreed that I should place in nomination the name of Dr. Robert S. Breakey for Councilor from the 2nd District.

J. D. VAN SCHOICK, M.D. (Jackson): I second it. I am sure most of the men here know Bob Breakey pretty well. I am sure all of us of the 2nd District know him well. We know that he is a man of action, sometimes of a good many words. Nevertheless, Bob is a patriot and a representative of any district he represents. So, on the part of Jackson County, it gives me great pleasure to second the nomination of Bob Breakey for Councilor from the 3rd District.

E. G. KRIEG, M.D. (Wayne): I move the nominations be closed and that the Secretary be instructed to cast a unanimous ballot.

The motion was severally seconded and carried.

XVI—b. COUNCILOR 3RD DISTRICT

THE SPEAKER: Nominations are in order for Councilor from the 3rd District.

H. C. HANSEN, M.D. (Calhoun): After a caucus of the delegates of the 3rd Councilor District, I am prepared to make a motion to nominate Dr. George W. Slagle as Councilor for the 3rd District. I hope you elect him.

R. A. SPRINGER, M.D. (St. Joseph): I represent the other portion of the 3rd Councilor District. It affords me great pleasure to wholeheartedly second the nomination of Dr. Slagle. He has a splendid personality, a splendid mind. At no time will he be anything but a credit to The Council.

P. E. SUTTON, M.D. (Oakland): I move the nominations be closed and the Secretary be instructed to cast a unanimous ballot.

R. A. SPRINGER, M.D. (St. Joseph): I second the motion.

Motion carried.

XVI—c. COUNCILOR 15TH DISTRICT

P. E. SUTTON, M.D. (Oakland): The 15th District is comprised of members from Macomb and Oakland. Within the memory of the delegation from Oakland there has never been a Councilor from Macomb. We have canvassed the situation very carefully among our confreres and we believe we have found an excellent man whom we would like to place in nomination for Councilor from the 15th District. I speak of Dr. Bruce Wiley, of Utica, Macomb County. He has been a delegate to this body for ten years. He is a past president of the County Society. He has been a very faithful secretary of Macomb County for ten years. In addition he was state chairman of the National Conference of County Medical Society Officers in 1947. Since 1947, he has been a member of the Executive Committee of the National Conference of County Medical Society Officers. He has been a member of the Michigan State Medical Society Public Relations Committee. He has served the 15th District as CAP chairman. The Oakland delegation are very confident that Dr. Wiley will make an excellent Councilor.

E. D. SPALDING, M.D. (Wayne): I am delighted to second the nomination of Dr. D. B. Wiley. Those of us who have been in the House for some time know him well. I am glad to offer a second to the nomination.

THE SPEAKER: The Speaker is very pleased to have the nomination of Dr. Wiley from this Councilor District.

R. L. NOVY, M.D. (Wayne): I move that nominations be closed and the Secretary be instructed to cast a unanimous ballot.

The motion was severally seconded and carried.

XVI—d. COUNCILOR FOR 16TH DISTRICT

G. C. PENBERTHY, M.D. (Wayne): It was with regret that the membership of the Wayne County Medical Society learned from Dr. Osius that he would prefer not to be placed in nomination. It is not necessary for me to tell this House of Delegates what Dr. Osius has contributed as a Councilor from the 16th District. We have seen him in action during this period, at this meeting. We regret to learn that Dr. Osius, due to extenuating circumstances, prefers not to have his name placed in nomination.

It is my privilege and pleasure to bring to you a friend of all of you, Wyman D. Barrett, to succeed Dr. Osius as the Councilor from the 16th District. You all are aware of and know Dr. Barrett's interest in organized medicine. He served on The Council of the Wayne County Medical Society, and is an ex-president of the Wayne County Medical Society. He is a member of the board and chairman of the Board of Trustees. At the present time he is a delegate to the House of Delegates of the American Medical Association, where each year his contributions are recognized.

It gives me great pleasure to place in nomination the name of Dr. Wyman D. Barrett, Councilor of the 16th District.

E. C. TEXTER, M.D. (Wayne): I would like to second the nomination of Dr. Barrett. It gives me great pleasure to do so.

H. B. FENECH, M.D. (Wayne): I move the nominations be closed and the Secretary be instructed to cast a unanimous ballot.

Motion carried.

XVI—e. DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

K. B. BABCOCK, M.D. (Wayne): As chairman of the Wayne delegation, it is my privilege and honor to place the name of Dr. Wyman Barrett in renomination.

G. C. PENBERTHY, M.D. (Wayne): I second it.

D. R. SMITH, M.D. (Dickinson-Iron): I wish to nominate as a delegate to the American Medical Association, to succeed himself, having just finished his first

term as a delegate to the AMA, Dr. W. H. Huron, of Iron Mountain.

E. D. SPALDING, M.D. (Wayne): I wish to place in nomination for the third position a stranger to all of you, a young man who is promising, none other than Dr. Robert Novy, to succeed himself.

THE SPEAKER: Are there any other nominations?

R. A. SPRINGER, M.D. (St. Joseph): I move the nominations be closed.

H. B. FENECH, M.D. (Wayne): I second the motion.

Motion carried.

THE SPEAKER: The three men nominated are elected as delegates to the American Medical Association. We have no ballots to count, and therefore the winner will be decided by drawing lots. The first one drawn will be the senior, the second one drawn will take his position correspondingly, and the third one will take his position correspondingly.

E. D. SPALDING, M.D. (Wayne): May I suggest an alternate method? That these men have their seniority in the House of Representatives determine their order. I will so move.

G. C. PENBERTHY, M.D. (Wayne): I second it.

THE SPEAKER: You mean seniority in this House of Delegates?

E. D. SPALDING, M.D. (Wayne): Seniority in their position as delegates to the American Medical Association.

G. C. PENBERTHY, M.D. (Wayne): They are now in their sequence.

Motion carried.

THE SPEAKER: Does Dr. Barrett have seniority at the present time?

G. C. PENBERTHY, M.D. (Wayne): That is right, and then Dr. Huron and then Dr. Novy.

THE SPEAKER: Then their seniority will remain the same.

XVI—f. ALTERNATE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

THE SPEAKER: Three persons are to be elected.

J. J. LIGHTBODY, M.D. (Wayne): I would like to place in nomination the name of Dr. Ralph A. Johnson as an alternate delegate to the AMA.

W. B. MITCHELL, M.D. (Wayne): I would like to place in nomination the name of Dr. R. H. Denham, Grand Rapids, as an alternate delegate to the AMA.

M. A. DARLING, M.D. (Wayne): I should like to place in nomination the name of Dr. Clarence I. Owen, to succeed himself as alternate delegate.

J. E. LOFSTROM, M.D. (Wayne): I would like to move that the nominations be closed and a unanimous ballot be cast for the nominees.

J. H. SCHLEMER, M.D. (Wayne): I second it.

Motion carried.

THE VICE SPEAKER: I am trying to find out if Dr. Spalding was out of order on his last motion. The following is an excerpt from the Constitution, relative to alternate delegates:

"The number of alternate delegates shall equal the number of delegates. They shall be elected in exactly the same manner after all delegates have been elected. Alternate delegates shall have relative seniority according to the respective number of votes received by them, and such seniority shall be designated at the time of election. Alternate delegates serving their second year shall hold seniority over those alternate delegates serving their first year in office; provided, however, that reelection as alternate delegate shall carry with it no additional seniority."

THE SPEAKER: Dr. Spalding, I must read another sentence here:

"In case of a tie vote of high candidates the winner, or winners, shall be decided by drawing lots; supervised by the Speaker of the House of Delegates; provided however, that any candidate thus tied shall have the right to a decision by ballot if he requests same."

That is on the delegates.

SECRETARY FOSTER: That should be the procedure, rather than Dr. Spalding's motion.

THE SPEAKER: I am afraid we have got to take a little time on the question of seniority. That will be done by drawing lots, unless some of the delegates wish it done by ballots.

J. R. HEIDENREICH, M.D. (Menominee): I move we suspend the rules and decide seniority by drawing lots.

E. D. SPALDING, M.D. (Wayne): You can suspend Robert's Rules of Order, but you cannot suspend the By-laws, even by unanimous vote.

SECRETARY FOSTER: It is important that we know who the first alternate is. Each year they move around, move up. The second moves up to first, and so on.

H. F. DIBBLE, M.D. (Wayne): To overcome the difficulty, why could we not vote for one alternate to take the position of the first alternate this coming year?

THE SPEAKER: May I suggest that that would mean two ballots. You might mark the ballots 1, 2 and 3, in the order in which you want them to have seniority. That would at least make it official.

I will appoint as tellers Dr. Sutton, Dr. Wiley, and Dr. Becker. We will first vote on the three delegates, Dr. Barrett, Dr. Huron and Dr. Novy. Mark your ballots 1, 2 and 3, in accordance with the way you wish them to have seniority.

Before you vote, gentlemen, the Chair wishes to point out that the motion of Dr. Spalding as accepted is not constitutional. We will vote by ballot, as instructed. The ballots are big enough, so I see no reason why you cannot vote for both the delegates and alternates, if that is acceptable to the House. Put the delegates on one side and the alternates on the other side. Be sure to number them.

(The balloting resulted in delegates and alternate delegates having the same seniority as previously.)

XVI—g. PRESIDENT-ELECT

DOUGLAS DONALD, M.D. (Wayne): I wish to place in nomination the name of a man who has served the House of Delegates and The Council of the Michigan State Medical Society for a period of many years. I think eleven, to be exact. For five or six years he was vice-chairman of The Council, and for three years has been chairman of The Council. I need not go into his other honors. I wish to say nothing more, except to place in nomination the name of Dr. Otto Beck for President-Elect.

L. G. CHRISTIAN, M.D. (Ingham): I support the nomination.

R. W. TEED, M.D. (Washtenaw): The delegation of Washtenaw County takes pleasure in unanimously seconding also the nomination of Dr. Beck.

W. B. MITCHELL, M.D. (Kent): I would move that the nominations be closed and the Secretary be instructed to cast a unanimous ballot for Dr. Otto O. Beck for President-Elect.

H. F. DIBBLE, M.D. (Wayne): I second the motion.

Motion carried.

(The members arose and applauded.)

THE SPEAKER: Dr. Beck, I want to shake your hand and congratulate you at this moment. I would like to have made the nomination, and I am very, very proud that you come from my county, and proud of your long years of service.

O. O. BECK, M.D. (Oakland): Thank you, Bob. Mr. Speaker, Members of the House of Delegates: I had hoped at this session to retire from active participation in the affairs of the Society because of personal reasons, not because I have not enjoyed the eleven years I have served on The Council and in various capacities. That period of time has been a joy to me, has been an experience such as only few of us have in a lifetime. It

is an education that comes to only a few to work for that length of time for such a fine organization as this is and for such a fine group of gentlemen. I am deeply humble. I feel a deep void of having the proper qualifications for this office. But I am entirely grateful to you for the confidence you have placed in me, and I want to thank you.

THE SPEAKER: Gentlemen, let us interrupt the proceedings for a moment. I think it is nice to look over the past presidents. I am sure there are several of them in the House. I wish they would come to the front of the room so they can at least be seen. We are very glad to have you all with us. We certainly appreciate your past services. We anticipate as good or better from you, Dr. Otto, in your office when you take over as President.

XVI—h. SPEAKER OF THE HOUSE OF DELEGATES

R. S. BREAKEY, M.D. (Ingham): This is probably the last time that I shall bother the House of Delegates. I should like to place in nomination the name of our present Speaker. I could spend some time in eulogizing. We have had Speakers in this chair for as long as periods of seven years. If we accepted Bob for seven years more we would be doing ourselves credit.

(W. E. Barstow, M.D., President, assumed the chair.)

J. M. MARKLEY, M.D. (Oakland): Oakland County takes great pleasure in seconding the nomination of Dr. Baker for Speaker of the House of Delegates.

R. W. TEED, M.D. (Wastenaw): I move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. Baker.

H. F. DIBBLE, M.D. (Wayne): I second the motion.

Motion carried.

VICE SPEAKER J. E. LIVESAY: Bob, it has been a pleasure working with you this year. Congratulations!

THE SPEAKER: Thank you very much, gentlemen of the House of Delegates. And thank you, Dr. Spalding. We almost sat you down tonight, with the help of the Vice Speaker who did a very nice job at my elbow. I have enjoyed this, in spite of various nervous moments during this session. You have been very kind. You have helped me out of one of my great weaknesses, not being able to call out your name when you get up on the floor. Now that you have tolerated me for one year I probably can learn something, after the lesson Ed Spalding gave me last night.

XVI—i. VICE SPEAKER OF THE HOUSE OF DELEGATES

E. D. SPALDING, M.D. (Wayne): We have had two new men presiding over this House of Delegates meeting this time. They have done an extraordinarily good job, with all the heckling they have had from the sidelines. I think the best way of showing our appreciation is to return these men to office.

It gives me great pleasure to place in nomination for Vice Speaker the name of Dr. J. E. Livesay, of Genesee County.

F. A. WEISER, M.D. (Wayne): I would like to second that.

R. A. SPRINGER, M.D. (St. Joseph): I move the nominations be closed and the Secretary be instructed to cast a unanimous ballot.

G. C. PENBERTHY, M.D. (Wayne): I second it.

Motion carried.

THE VICE SPEAKER: Thank you for your vote of confidence, gentlemen.

THE SPEAKER: Thank you very much, gentlemen. We certainly appreciate all you have done.

I declare the 85th Annual Session of the House of Delegates of the Michigan State Medical Society now adjourned.

XVII—Adjournment

The House of Delegates adjourned at 9:30 p.m.

NEW INFLUENZA VIRUS DISCOVERED

(Continued from Page 1445)

from a group of children, ages one to five and one-half years, in the studies. Tests of serums obtained from patients among the students at the University of Michigan ill with influenza during the epidemic phases of 1947 and 1950 showed little reaction to the new virus, indicating the possibility that adults might not show a measurable response to infection with this virus. Attention was then turned to young children who would be less experienced and whose antibody responses would be more likely to reflect the occurrence of infections.

Blood samples tested in 1947 from children who had been vaccinated with the PR8 strain of Type A influenza in the fall of 1946 showed a rise in antibodies to the virus, indicating that there had been a wide exposure to this virus.

Tests of serums from another group of children, taken in 1947, showed rises in antibodies to both the A-prime, a sub-type of A group influenza, and the new virus. This gave evidence that the two diseases were concurrent in the population and of about the same incidence during the spring of 1947, and that they are immunologically independent.

A high incidence of antibodies in adults tested strongly indicated that the population has been thoroughly seeded with the new virus strain. Research also showed that the virus has been circulating since at least 1936.

Symptoms in adults are not yet well outlined, but fever, cough and the ordinary head cold were the common signs in children.

"The association of the epidemic disease with influenza, the basic clinical picture, and the wide distribution of antibodies in the human population, as well as the serological and immunological characteristics of the virus readily invite consideration of the name, Influenza C," the paper concludes. "Further studies, a number of which are under way, will determine the appropriateness of this suggestion."

MSMS

Cytologic examination of sputum is of great diagnostic value in the case of patients suspected of bronchogenic cancer when bronchoscopic examination is contraindicated.

* * *

Cancer of the lung must be differentiated from pulmonary abscess, pneumonia, benign tumor, and tuberculosis.

POSTGRADUATE CONTINUATION COURSES

Wayne University College of Medicine

December 4, 1950-March 10, 1951

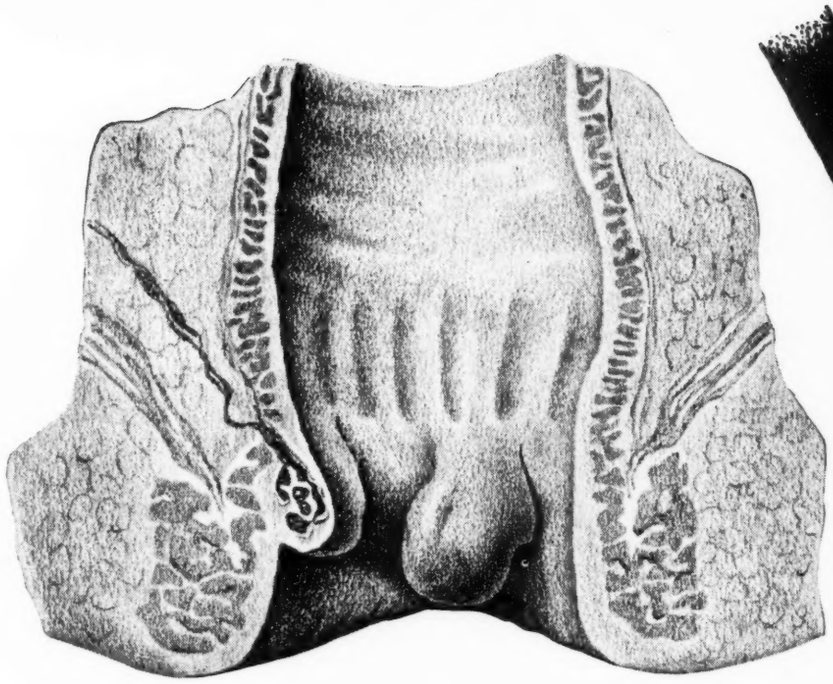
These courses are open to all qualified persons.

Veterans who are not Residents in a Detroit hospital and who have Certificates of Eligibility under the GI Bill, should make arrangements for tuition and books, as provided by the GI Bill, by presenting these Certificates of Eligibility to Dr. Arthur Johnson, Veterans Administrator at Wayne University, 5115 Second Avenue, Detroit, Michigan.

If you do not possess a Certificate of Eligibility, please call Dr. Johnson at Temple 1-1450, Veterans Affairs, before going to his office, and he will inform you what papers it is necessary to bring with you. *This must be completed before you register.*

Registration for these courses can be made in the office of Postgraduate Medical Education at the College of Medicine, 1512 St. Antoine.

Title of Course	*Place*	*Time*	*Fee*
	Anatomy		
Surgical Anatomy (Two Quarters) (Limited to 20 Senior Surgical Residents)	College of Medicine	Tuesday 3:00-5:00	$35.00
	Physiological Chemistry		
Seminar in P. Chemistry	College of Medicine	Thursday 3:30-4:30	$15.00
Intermediary Metabolism	College of Medicine	Friday 1:00-2:00	$15.00
	Pathology		
Gynecologic Pathology (Every doctor must have microscope)	College of Medicine	Wednesday 1:00-5:00	$50.00
Path. of Parasitic Diseases	College of Medicine	Monday 1:00-5:00	$50.00
Neuropathology	College of Medicine	Friday 1:00-5:00	$50.00
Advanced Hematology (Limit 5)	College of Medicine	Monday 1:00-5:00	$50.00
	Dermatology		
Seminar in Dermatology	Receiving Hospital	Wednesday 10:00-11:30	$15.00
Dermopathology Seminar	College of Medicine	Tuesday 11:00-12:00	$15.00
Conf. on Venereal Diseases	Social Hygiene Clinic	Thursday 1:00-2:30	$15.00
	Internal Medicine		
Medical Conference	Receiving Hospital	Wednesday 5:00-6:00	$15.00
Gastroenterology	Receiving Hospital	Saturday 8:00-9:00 a.m.	$15.00
Medical Seminar	Receiving Hospital	Thursday 6:30-7:30	$15.00
Medical X-Ray Conference	Receiving Hospital	Tuesday 11:00-12:00	$15.00
Allergy Clinic & Conference	Receiving Hospital	Tuesday 8:00-11:00 a.m.	$25.00
	Surgery		
Surgery Seminar	College of Medicine	Monday 4:00-5:00	$15.00



Bowel Regulation in Hemorrhoidal Conditions

When there is a tendency toward hemorrhoids, when hemorrhoids are present or after hemorrhoidectomy—when avoidance of straining is desired—Metamucil's smooth, demulcent action conforms to accepted bowel management.

Metamucil softens the fecal content, stimulates peristalsis by supplying plastic, bland bulk and encourages easy, gentle, regular evacuation without irritation or straining.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

G. D. Searle & Co., Chicago 80, Illinois.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

METAMUCIL®

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

The Division of Laboratories, Michigan Department of Health, is changing the method of reproduction of laboratory reports to give full size readable black and white copy.

The success of the new method of reproduction is dependent on:

1. The use of translucent paper originals, now being supplied to physicians.
2. The preparation of readable and reproducable copy in the doctor's office.
3. The preparation of readable copy in the Laboratories.

In order that the copy of the laboratory report may reach the doctor's office promptly and in usable condition, the doctor's portion of the copy must be prepared by one of the following methods:

1. Typewritten, using heavy black ribbon.
2. Handwritten, using heavy black, blue black, dark green, brown, or dark red liquid inks, heavy black or red ballpoint pen inks or a No. 2 or softer lead pencil. Light blue, water blue, and light green liquid inks, and blue, green and violet ballpoint pen inks do not reproduce well.
3. Handstamped, using a stamp well-inked with black ink. Light or smudged copy will not reproduce well.

The reproduced copies will be mailed in window envelopes. Illegible or incomplete addresses will seriously delay receipt of the reports in the doctors' offices.

The co-operation of physicians in preparation of reproducable originals is requested.

* * *

Food samples suspected of being the source of illness which are submitted to the Division of Laboratories, Michigan Department of Health, for examination must be accompanied by a statement in sufficient detail to incriminate the food epidemiologically. This statement must be signed by the local health officer.

* * *

Calibration and preliminary test runs on a new automatic recording x-ray spectrometer have been completed by the Division of Industrial Health, Michigan Department of Health. The new equipment will facilitate the determination of silica and dust found in the foundry, mining, pouring, cleaning and cutting industries in the state. Its fast and accurate analysis of silica-bearing dusts will aid in the detection and correction of conditions which cause silicosis in Michigan.

* * *

One out of every 109 people who had their chests x-rayed at Michigan's 1950 fairs has suspected tuberculosis.

Mobile tuberculosis case-finding units of the Michigan Department of Health, operating at thirty-one fairs and festivals this summer and fall, x-rayed the chests of 56,658 persons and found 1,087 chest abnormalities, including 519 cases of suspected tuberculosis which otherwise might have gone undetected.

Where the small x-ray film indicated a chest abnormality, the individual was advised, by mail, to see his physician for a complete examination and any needed treatment. About half of the abnormalities found on the x-rays appeared to be due to conditions other than tuberculosis—heart disease, pneumonia, silicosis and tumors or cancers.

* * *

To assist in determining the cause of death of many research animals on the National Foundation for Infantile Paralysis monkey farm, L. P. Hedeman, D.V.M., and Serge Lensen, Ph.D., of the Division of Laboratories, were called to Savannah, Georgia, in November.

* * *

Ultraviolet irradiation equipment for the destruction of infectious hepatitis virus in human blood and plasma, largely designed and developed in the laboratories of the Michigan Department of Health, was displayed by the Department before the American Association of Blood Banks Convention in Chicago. The Michigan-designed equipment is now being used by the National Institute of Health, the Army, the Navy, and major hospitals, health departments, blood banks and drug manufacturers throughout the world.

* * *

The Michigan Department of Health, which continually advises regular physical examinations for protection against diabetes and its complications, took a leaf from its own notebook and made arrangements for urinalysis of each of its employes who desired the examination during National Diabetes Detection Week.

* * *

E. J. MacLachlan, D.V.M., who had served as director of the Jackson City Health Department since 1935, retired September 15, 1950, after thirty years of service with the Department. Dr. MacLachlan served as dairy and food inspector with the Jackson Department from 1920 until his appointment as director on October 16, 1935.

F. I. VanWagnen, M.D., was named acting director of the Jackson City Health Department to serve until a full-time director is appointed.

* * *

Approximately forty Michigan people die of accidental carbon monoxide poisoning each year.

* * *

Edward Dunbar Rich Service awards for twenty-five years of service in providing safe public water supplies were given to seventy-nine municipal water works employes from twenty-three Michigan cities in 1950.

Communications

October 30, 1950

Dr. Wilfrid Haughey, Editor
610 Post Building
Battle Creek, Michigan

Dear Dr. Haughey:

I have read with a great deal of interest the various articles appearing in the October issue of the MICHIGAN STATE MEDICAL JOURNAL.

These are not only of interest to me as an individual but by virtue of the fact that I happen to be president of the local cancer society. I might say that I am rather proud of the contribution made by various Kalamazoo doctors to this particular issue.

I wish to congratulate you upon the selection of the articles as it appears to be a very excellent job.

Yours very truly,

WADE VAN VALKENBURG
House of Representatives
Lansing, Michigan

* * *

November 1, 1950

Dear Doctor:

We enclose a resolution passed at a meeting of a committee of the International and Fourth American Congress on Obstetrics and Gynecology held in May, 1950, in New York City. We venture to hope that you will bring this before your society, and will try to persuade your society to adopt such an international classification for the better understanding of the statistics published in the various countries, and to make it possible to compare such statistics.

Sincerely yours,

FRED L. ADAIR, M.D.
For The International Congress
on Obstetrics and Gynecology

Resolution Adopted on Classifications of Cervical Cancer

Whereas the so-called League of Nations' Classification of Carcinoma of the Uterine Cervix is now in common use in many countries, but is not used exclusively in the United States of America, it is desirable that this classification, or an acceptable modification thereof, be adopted universally in order to reach a common ground of understanding. Therefore, a committee of duly appointed representatives of the Section of Obstetrics and Gynecology of the American Medical Association, the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, and the American Gynecological Society, meeting in session with the *Editorial Committee of the Annual Report on the Results of Radiotherapy in Carcinoma of the Uterine Cervix* on the occasion of the International and Fourth American Congress on Obstetrics and Gynecology at New York City on May 14-19, 1950, has agreed to propose the following modification of the classification adopted by the Health Organization of the League of Nations in 1937:

Stage O

Carcinoma *in situ*—also known as preinvasive car-

cinoma, intra-epithelial carcinoma and similar conditions.

Stage I

The carcinoma is strictly confined to the cervix.

Stage II

The carcinoma extends beyond the cervix, but has not reached the pelvic wall. The carcinoma involves the vagina, but not the lower third.

Stage III

The carcinoma has reached the pelvic wall. (On rectal examination no "cancer-free" space is found between the tumor and the pelvic wall.)
The carcinoma involves the lower third of the vagina.

Stage IV

The carcinoma involves the bladder or the rectum, or both, or has extended beyond the limits previously described.

Be it resolved that this Classification be termed the International Classification of the Stages of Carcinoma of the Uterine Cervix, and that all organizations concerned with the problem on hand be approached to consider its adoption.

Committee

(Section of Obstetrics and Gynecology, American Medical Association)
Roy Calkins, M.D.
Walter Dannreuther, M.D.
William Mengert, M.D.

(American Gynecological Society)
Herbert Schmitz, M.D.
Ludwig Emge, M.D.
William P. Healy, M.D.

(American Association of Obstetricians, Gynecologists, and Abdominal Surgeons)
Bayard Carter, M.D.
Robert Faulkner, M.D.
James Corscaden, M.D.

(Editorial Committee, Annual Report of Results of Radiotherapy in Carcinoma of the Uterine Cervix)
James Heyman, M.D.
Malcolm Donaldson, M.D.
Joe V. Meigs, M.D.

SYSTOLIC MURMURS

(Continued from Page 1440)

References

1. Auerback, A., and Gliebe, P. A.: Iatrogenic heart disease. J.A.M.A., 129:338, 1945.
2. Boone, J. A., and Levine, S. A.: The prognosis in "potential heart disease" and "rheumatic mitral insufficiency." Am. J. M. Sc., 195:764, 1938.
3. Cowan, J., and Ritchie, W. T.: Diseases of the Heart. Ed. 2. London: Edward Arnold and Co., 1922.
4. Kuttner, A. G., and Markovitz, M.: The diagnosis of mitral insufficiency in rheumatic children. Am. Heart J., 35:718, 1948.
5. Levine, S. A., and Harvey, W. P.: Clinical Auscultation of the Heart. Philadelphia: W. B. Saunders Co., 1949.
6. Lewis, Sir Thomas: Diseases of the Heart. New York: The Macmillan Co., 1933.
7. Mackenzie, Sir James: Principles of Diagnosis and Treatment in Heart Affections. London: Oxford University Press, 1917.
8. Nomenclature and Criteria for Diagnosis of Diseases of the Heart. Ed. 4. New York: New York Heart Association, Inc., 1945.

. . . . . NEWS MEDICAL

Income Tax.—The Internal Revenue Bureau has ruled that the amount which employers pay toward employes' hospital and medical insurance on group basis is actually an increase in wages and tax must be made upon this. An appeal has been through Blue Cross and Blue Shield to get this clarified. Medical and hospital expenses identified with workman's compensation are recognized as tax exempt. It may be necessary to amend the law.

* * *

Ewing Denies Allegation.—Your correspondent last week brought to attention of Federal Security Administrator Oscar R. Ewing a charge by Dr. L. Fernald Foster, secretary of Michigan State Medical Society, that "$75 million of your tax money (was) admittedly spent by Mr. Oscar Ewing to convert you to the belief that compulsory health insurance is a necessity." Via his secretary, the Administrator issued a denial of Dr. Foster's allegations (contained in a pre-election radio talk) but demurred at discussing the question with your correspondent.—WRMS, November 13, 1950.

Editor's note: The Harness report is one authority for Dr. Foster's figures. Several other congressional reports give the same information.

Pharmacists Feud with FDA over Prescription Refills.—November issue of *Journal of American Pharmaceutical Association* (Practical Pharmacy Edition) carried an acidulous editorial, entitled "Confusion," deploring position of Food and Drug Administration in holding that physicians' prescriptions are not refillable. FDA's stand is intended to prevent habitual use of barbiturates and other dangerous drugs. Editorial complains that FDA refuses to publish an official ruling on the subject and won't hold public hearings to iron out differences.

"Neither pharmacy nor medicine exist as professions by the grace of the Food and Drug Administration," it says. "They were the trusted servants of the people in health matters long before there was any Federal Food, Drug and Cosmetic Act. By their codes of ethics and by fostering necessary state laws, they have given ample proof of their interest in safeguarding public health."—WRMS, November 13, 1950.

* * *

570 "Loanouts" on Duty.—All 570 naval medical Reserves ordered to active duty, for assignment to Army stations on temporary loan, have now completed their indoctrination courses at Fort Sam Houston, Texas, and been sent to military hospitals and posts in United States and overseas. Execution of the task of calling them into uniform—many of them on as little as two weeks' notice—and conditioning them to serve with a different military branch from the one they originally elected demanded utmost consideration. That the joint efforts of Army and Navy were successful is attested by numerous letters received last week by Brig. Gen. Paul Robinson, chief of Army medical personnel, expressing thanks for care which was exercised in making duty assignments as well as for courtesies and privileges that were extended to these former V-12's while they were undergoing indoctrination at an Army base.—WRMS, November 13, 1950.

* * *

The Oregon Case.—The Department of Justice has indicated that it will appeal to the Supreme Court Judge Claude McCalloch's decision in the case of the United States against Oregon State Medical Society, Oregon Physicians Committee, eight medical societies and eight doctors, in which Judge McCalloch's decision that the government had not proved its charge of conspiracy.

If this case is not appealed, the government's contemplated cases against societies and medical service organizations will be very much weakened.

Judge McCalloch's decision is far reaching and specific.

* * *

Michigan Authors.—

Clifford C. Benson, M.D., and **Harvey R. Sharpe, Jr., M.D.**, of Detroit, published an article, "Recent Ex-

periences with Intestinal Resection in Infants and Children," in the AMA *Archives of Surgery,* November, 1950.

H. T. Langston, M.D.; W. M. Tuttle, M.D., and **T. B. Patton, M.D.,** of Detroit, published an article, "Esophageal Duplications," in the AMA *Archives of Surgery,* November, 1950.

Sidney Friedlaender, M.D., and **Alex S. Friedlaender, M.D.,** Detroit, published an article on "The Effect of Pituitary Adrenocorticotropic Hormone (ACTH) on Histamine Intoxication and Anaphylaxis in the Guinea Pig" in the **Journal of Allergy,** July, 1950.

* * *

"In 1916, Lenin advised Swiss workers that direct federal taxation would be an instrument through which Switzerland could be socialized. The same for the United States!"—**The Foundation for Economic Education, Inc.,** New York.

* * *

VA Hospital Committee Recommends Changes.—A special committee appointed in June to investigate VA's hospital program has made its report to President Truman. (Dr. Howard A. Rusk, chairman; Dr. Arthur S. Abramson, Rear Adm. Robert L. Dennison.) The report praises VA medical care in general and singles out paraplegic centers and amputee programs for special commendation. Highlights of the report: Challenges Congress to make new interpretation of politically hot policy covering care of non-service connected cases, which VA says take up at least two-thirds of its hospital beds. Declares that VA cannot hope to provide present high-quality staffing for 131,504 beds now authorized, and suggests 120,000 as a safe maximum; this is a rebuke to Congress for authorizing additional construction in opposition to the President. Advised the Armed Forces to transfer to VA all patients not expected to be returned to duty; VA would provide specialized rehabilitation treatment; men to remain on military status and be discharged only on attaining maximum improvement. Urged that non-service connected amputees and paraplegics be given sixty days of home service care (not now allowed for any non-service cases) and that a special job-placement service be set up for paraplegics. Armed Services advised, as long-term policy, not to carry VA medical employes on their reserve rolls; as short-term expedient, not to call up such present reserves. Report to the President from the Committee on Veterans' Medical Services is for sale by Superintendent of Documents, Government Printing Office, Washington 25, D. C., for 25 cents.

September reports on VA show 68,453 non-service connected cases were hospitalized and 35,236 service-connected cases.

* * *

Medical Books for Europe.—CARE (20 N. Broad St., New York).—Nearly one million dollars in contributions and pledges have been received to provide the books on scientific equipment for educational institutions overseas, and 378 institutions in twenty-four countries have benefited. Over fifty thousand books and periodicals were sent. Contributions of any amount are accepted.

Michigan Pathological Society.—The fall meeting of the Michigan Pathological Society was held in Detroit on September 22, in conjunction with the annual meeting of the Michigan State Medical Society. The scientific portion of the meeting was devoted to a seminar on "The Pathology of the Pituitary, Parathyroid, Islet Tissue of the Pancreas, and of the Adrenals." Over twenty cases were presented, and Dr. John R. McDonald of the Mayo Clinic acted as moderator. A demonstration on disaster blood procurement was also conducted during the three-day session of the State Medical Society which included drawing of blood and a standardized method of typing.

* * *

Hospital Standardization.—At their meeting October 21, 1950, in the Hotel Statler, Boston, the Regents of the American College of Surgeons voted unanimously to continue the Hospital Standardization Program of the College.

A spokesman for the Regents stated that this action does not necessarily preclude consideration of proposals for the participation of other interested agencies in this program, but does make it clear that the American College of Surgeons has an undiminished interest in it and will consider no proposal which will not insure its continuation in the best interests of the public.

* * *

Dr. Hartman A. Lichtwardt, director of Women's Hospital, Detroit, spoke before the Detroit Accident and Health Association's October breakfast meeting, and had some vital points on the subject of compulsory socialized medicine. Dr. Lichtwardt noted that a new Government hospital in Minot, S. D., cost $38,000 per bed to build. The same hospital facilities could be built in Detroit today—at Detroit's high prices—for less than $18,000 per bed! He noted, too, that when he visited this great edifice, there was but one patient—costing taxpayers $1,900 a day. He pointed out that the stay in Government hospitals is just twice as long as it is in private and public hospitals.

* * *

AMA Replies to Ewing's New York Talk.—Federal Security Administrator Ewing struck an all-time low in political speech-making when he injected the racial issue in his attacks upon the American Medical Association.

In a speech before the American Jewish Congress, Mr. Ewing as usual upbraided the AMA for many "deficiencies," and then accused medical schools of practicing discrimination against Jews. While he did not lay this discrimination on the AMA's doorstep directly, the strong implication was there just the same. Newspapers published his statements. Within twenty-four hours the AMA countered with a news release which was given good prominence in most of the big papers. The AMA release said:

"The American Medical Association, in a blistering indictment of Federal Security Administrator Oscar Ewing which stated that he had twice been given a vote of 'no confidence' in Congress, to-day (September 29) characterized him as a 'disappointed, embittered bureaucrat,

who should be removed from office before he does further harm to the country.' "

Dr. George F. Lull, Chicago, general manager of the AMA, who issued the statement, declared:

"Mr. Ewing, in his speech yesterday (September 28) before the American Jewish Congress, descended to the depths of political demagoguery when he falsely implied that the American Medical Association was practicing discrimination against Jews.

"He has long been a fomenter of class hatreds and he is now attempting to incite religious and racial hatreds in the manner of Hitler's Germany.

"Mr. Ewing is a case of arrested political development and his irrational statements undoubtedly are a consequence of thwarted ambitions and a growing persecution complex. He is wholly unfit for public office.

"The two Houses of Congress, in successive years, have given Mr. Ewing a decisive vote of 'no confidence,' by rejecting his attempts to gain Cabinet stature and control over the medical profession through the creation of a Department of Health, Education and Security.

"President Truman should finish the job and dismiss Mr. Ewing from the public service before he does further harm to the country."

* * *

Senate's Study of Manpower.—The Armed Services Committee of the Senate has been collecting facts on national manpower, particularly with reference to military potential. The objective is to examine into the working of the Selective Service law, including the doctor draft.

Although traditionally this committee's primary concern is with our armed forces, its members recognize the fact that a convenient separation of military and civil aspects is impossible. They want to find out the proper ratio of physicians to population which is being done at a "target center." They are fully indoctrinated with the Army's goal of 6.5 medical officers per 1,000 troops and 2 dental officers per 1,000 troops. The committee promises to investigate these ratios.

The heavy registration of young draft-vulnerable physicians and dentists throws this problem of manpower allocation into sharp relief. Doctors are being commissioned without regard to their value and essentiality in present civil pursuits. National Security Resources Board's health advisory committee presumably is studying that question but, in the meantime, hospitals are wondering how far their residency losses will be allowed to go and local communities are wondering whether there is anything to prevent surrender of a village's sole practitioner to Army or Navy.

* * *

Training Courses in Radiological Health.—The School of Public Health of the University of Michigan at Ann Arbor conducts what they call Inservice Training Courses in timely subjects. Announced for February 5 to 8, 1951, is a noncredit training course in "Radiological Health." Lectures and courses start a 9:00 a.m., Monday, February 5 and continue, including films on atomic

energy, to 5:00 o'clock; Tuesday and Wednesday from 8:30 until 5:00. Thursday closes with a discussion on "Public Health Aspects of Civilian Defense from Atomic Weapons" by James P. Cooney, Brigadier General, Division of Military Application, U. S. Atomic Energy Commission, Washington, D. C. Any one interested in this course may obtain a complete program by writing, H. E. Miller, M.D., School of Public Health Building, Ann Arbor, Michigan.

* * *

Health Insurance Fight Still in "Congressional Record."—The October 20 issue of the *Congressional Record* carries on a debate over "socialized medicine." Rep. Henry J. Latham (R., N. Y.) brands Federal Security Agency "propaganda machine" for national health insurance as "a law unto itself." Senator Harry F. Byrd (D., Va.) inserts, on October 9, an address by Dr. W. C. Caudill, president of Virginia Medical Society, who warns that the future is lost "if we permit the heady wine of socialism to dull our sensibilities and destroy our initiative." A few pages beyond, Rep. Andrew J. Biemiller (D., Wis.) berates AMA anew and appends complete text of *Atlantic Monthly* article by Dr. James Howard Means, entitled "The Doctors' Lobby."

Another provocative topic in the October 20 *Record* is interspersal of civil and military physicians and dentists at all armed forces' posts and stations within continental limits of U.S. for purpose of utilizing medical manpower to the full. Professional services to military personnel should be in charge of county medical societies or other local medical groups. "There seems to be no justifiable reason why every military base within the U.S., and even some of the foreign bases, cannot be efficiently staffed and operated by civilian physicians and by inducted physicians disqualified for combat duty," says the scheme's author, Dr. D. W. Kingsley, of Hastings, Neb. Congressional sponsor of the plan is Senator Hugh Butler (R., Neb.).

* * *

American Academy of Neurology Announces Official Publication.—As a reflection of the proved recognition of neurology as an integral and essential part of medicine, the American Academy of Neurology announces the establishment of its new publication, *Neurology*, the first issue of which will be mailed January, 1951.

Neurology, the only American journal devoted exclusively to neurology, will be published bimonthly. Its editorial scope will embrace every aspect of clinical neurology including diseases of the nervous system, neuropathology, neurosurgery, neuroanatomy, neurophysiology and neuropsychiatry. The editor-in-chief is Russell N. DeJong, M.D., professor and chairman of the Department of Neurology, University of Michigan.

The establishment of *Neurology* will mark a significant advance in the progress of American medicine, dedicated as it is to fostering a greater knowledge and understanding of nervous diseases. The journal will constitute an authoritative medium of information and discussion for both the specialist and the general practitioner. With interest in neuroses and their action on the physical make-up of the human being increasing more and more

each year, the importance of the subject of neurology to every practicing physician is becoming increasingly evident.

Neurology will be the one journal to survey and bulletin the changing aspect of neurology. It will touch the sensitive spots of clinical procedure and discovery by publishing original papers on the results of practice and research. Address Lancet Publication, Inc., Minneapolis, Minnesota.

* * *

State Health Officers Oppose Socialized Medicine.—Meeting in Washington, the Association of State and Territorial Health Officers reaffirmed its opposition to national compulsory health insurance and renewed its demand for creation of a federal department of health with cabinet status" . . . and under direction of a career physician in public health."

National health insurance is unnecessary, the resolution says, because voluntary health and hospitalization plans are "rapidly and progressively developing to meet the apparent needs of the people."

* * *

Jackson County Clinic Day—The program of the Jackson Clinic to be held February 8, 1951, at Hotel Hayes, Jackson, Michigan, is as follows:

1. "The Place of Allergy in the Practice of Medicine"—Jonathan Forman, M.D., Columbus, Ohio
2. "Carcinoma of the Colon"—Leland S. McKittrick, M.D., Brookline, Mass.
3. "Gynecological Physiology"—Somers Sturgis, M.D., Boston, Mass.
4. "Treatment of Superficial Lesions of the Skin"—U. V. Portmann, M.D., Cleveland, Ohio

The program will begin at 2:00 p.m., followed by a reception and dinner, at which Dr. Forman will be guest speaker.

The committee in charge is composed of N. D. Munroe, M.D., chairman, A. M. Shaeffer, M.D., W. E. McGarvey, M.D., D. F. Kudner, M.D., and H. W. Porter, M.D

* * *

The American Board of Ophthalmology announces its written Qualifying Tests for 1951: practical examinations will be given in San Francisco, March 11-16; in New York, May 31-June 5; and Chicago, October 8-13.

For detailed information, write Secretary-Treasurer Edwin B. Dunphy, M.D., 56 Ivie Rd., Cape Cottage, Maine.

* * *

The American College of Surgeons announces that one of its sectional meetings will be held in Detroit May 10-11, 1951. For program, write American College of Surgeons, 40 E. Erie St., Chicago 11, Illinois.

* * *

The Fifth American Congress on Obstetrics and Gynecology, sponsored by the American Committee on Maternal Welfare, Inc., will be held in Cincinnati from March 31 to April 4, 1952, at the Netherland Plaza Hotel.

Ingham County (Lansing) Clinic Day, May 3, 1951

The annual May Clinic of the Ingham County Medical Society will be held Thursday, May 3, 1951 at the Hotel Olds, Lansing. The program is as follows:

Afternoon Session 2:00 P.M.

1. "Re-evaluation of the Indications for Hysterectomy." Ralph A. Reis, M.D., Associate Professor of Obstetrics and Gynecology, Northwestern University, Chicago, Illinois.
2. "Recent Developments in the Diagnosis and Management of the Diarrheal Diseases." Joseph S. D'Antoni, M.D., Clinical Professor of Tropical Medicine, Tulane University, New Orleans, Louisiana.
3. "Recent Advances in Vascular Surgery and Diagnosis in Vascular Disease." Harris B. Shumaker, Jr., M.D., Professor of Surgery, University of Indiana, Indianapolis, Indiana.
4. Round Table. Moderator: I. Snapper, M.D., Director of Medical Education, Mount Sinai Hospital, New York, New York.

5:00 p.m. Social Hour.

6:30 p.m. Subscription Dinner. Speaker: I. Snapper, M.D., Director of Medical Education, Mount Sinai Hospital, New York, New York.
Subject: Liver Function Tests.

All members of the Michigan State Medical Society are invited to attend. No registration fee.

Woman's Auxiliary to the Michigan State Medical Society: Officers for 1950-51 are—President: Mrs. Oscar D. Stryker, St. Clair Shores; President-Elect: Mrs. Robert S. Breakey, Lansing; First Vice President: Mrs. Wm. Mackersie, Detroit; Second Vice President: Mrs. Walter Stinson, Bay City; Recording Secretary: Mrs. Martin Bruton, Saginaw; Corresponding Secretary: Mrs. R. M. Leitch, Union City; and Honorary President: Mrs. Guy Kiefer, East Lansing.

* * *

Doctors' Income Letters.—The third series of letters requesting physicians to fill in and return their income survey questionnaires has been sent out.

These letters come from the Commerce Department and are going only to those who did not return the coded questionnaire received during the summer.

The American Medical Association and the Department of Commerce expect this last appeal will bring the total returns to about 50 per cent.

* * *

The Chicago Medical Society's Annual Clinical Conference will be held at the Palmer House, March 6 to 9, 1951.

* * *

Salt water taken by mouth, in the vast majority of cases, is as effective as blood plasma in the emergency treatment of shock from serious burns and other injuries, according to the report of a group of leading

American surgeons to the Public Health Service. A member of the study group was F. A. Coller, M.D., Ann Arbor.

* * *

Grants to aid mental health training for psychiatrists, et al, recently announced by the Public Health Service, Federal Security Agency, totalling $1,915,708, included $46,866 to the University of Michigan and $12,500 to Wayne University College of Medicine, Detroit.

Heart teaching grants totalling $735,854 were made by the Public Health Service, Federal Security Agency, with the University of Michigan School of Public Health receiving $12,000 and Wayne University, Detroit, receiving $14,000, annually, over a two-year period.

Research in diabetes was authorized by the Public Health Service, Federal Security Agency, in total grants amounting to $855,740, with the following grants in Michigan: Alvin Zander, M.D., University of Michigan, $32,616; Joseph W. Eaton, M.D., Wayne University, Detroit, $19,364.

* * *

About one million hospital beds exist in the United States, according to Dr. John Cronin, Director of the Federal Hospital Construction Program. "An analysis of the country's needs, reflected in state planning, indicates 900,000 more beds are required just to meet the country's normal peacetime needs" stated Dr. Cronin.

* * *

The Michigan Proctologic Society will hold a meeting on Wednesday, March 14, during the 1951 Michigan Postgraduate Clinical Institute, Book-Cadillac Hotel, Detroit. Pre-prandial at 6:30 p.m. followed by dinner at 7:00 p.m. For program and information write E. F. Sladek, M.D., President, Traverse City, Michigan, or J. W. Becker, M.D., Secretary, 952 Maccabees Building, Detroit.

* * *

Jack Pickering, ace science writer of the **Detroit Times,** was guest speaker at the Bay County Medical Society's annual meeting, December 20, in Bay City.

* * *

The American College of Surgeons elected Alton Ochsner, M.D., of New Orleans as President-Elect, during its Boston meeting on October 26, 1950. He will succeed the present President, Henry W. Cave, M.D., of New York City. Other officers selected were Thomas H. Lanman, M.D., Boston, as First Vice President, and Joel W. Baker, M.D., Seattle, Second Vice President. Among the Board of Regents, four Michigan men were elected: George J. Curry, M.D., Flint, Charles S. Kennedy, M.D., Detroit, James W Logie, M.D., Grand Rapids, and Grover C. Penberthy, M.D., Detroit.

A testimonial of appreciation was presented to retiring President Fred H. Coller, M.D., of Ann Arbor.

* * *

The March of Dimes—Every American has a stake in the 1951 March of Dimes January 15 through 31. Upon the individual contributions received depends the future of the fight against infantile paralysis.

Each dime and dollar given to this fund-raising drive of the National Foundation for Infantile Paralysis is urgently needed this year—to provide assurance of ade-

quate care for all those who cannot pay full costs without help. The National Foundation ends 1950 with patient care funds exhausted and many bills unpaid. For the second successive year, its epidemic aid funds were insufficient for the job. The deficit must be met and its epidemic aid funds must be replenished.

During the years 1949-50 a total of some $47,000,000 was spent for polio patient care alone. There is no telling how much will be needed to cope with patients already stricken who will still need care in 1951, nor is there any way of predicting how many new cases will be added to the tragic roster.

The past three years have seen staggeringly high case incidence. No one knows if the trend will continue. But should there be a welcome "light" year ahead, the National Foundation's responsibilities are heavy.

The time to prepare is **now**. During the 1951 March of Dimes, January 15-31, give, and give again. Safeguard **your** stake in the fight against polio!

* * *

Henry W. Meyerding, M.D., of Rochester, Minnesota, assumed the presidency of the United States Chapter, International College of Surgeons, at the end of the 15th Annual Assembly of the College in Cleveland on November 3. Other officers elected are: President-elect, William R. Lovelace, M.D., Albuquerque, N. M.; Vice Presidents: W. W. Babcock, M.D., Philadelphia, O. S. Lowsley, M.D., New York, L. A. Buie, M.D., Rochester, Minn.; Moses Behrend, M.D., Philadelphia, C. J. Hunt, M.D., Kansas City; Secretary, Arnold S. Jackson, M.D., Madison, Wisc.; Treasurer, Oscar B. Nugent, M.D., Chicago; Members, Board of Trustees: Vernon A. Mastin, M.D., St. Louis, Mo., Elmer Hess, M.D., Erie, Pa., Oscar B. Nugent, M.D., Chicago, and E. L. Henderson, M.D., Louisville, Ky.

The International Board of Surgery Honorary Chairman is W. W. Babcock, M.D., of Philadelphia, and the other officers are: Chairman: R. W. McNealy, M.D., Chicago, Vice-Chairman: Harry E. Bacon, M.D., Philadelphia, Secretary: Karl A. Meyer, M.D., Chicago.

At this Assembly, 703 Doctors of Medicine were inducted into the College, including the following from Michigan: Fellows: H. F. Mullenmeister, M.D., Battle Creek, H. J. Van Duine, M.D., Grand Rapids, Ralph Wadley, M.D., Lansing, W. H. Honor, M.D., Wyandotte, J. J. Kraus, M.D., Detroit, R. G. Robinson, M.D., Detroit, W. H. Steffenson, M.D., Grand Rapids, C. L. Straith, M.D., Detroit; Associates: M. A. Martzowka, M.D., Roscommon, M. S. Roberts, M.D., Kalamazoo.

* * *

Nine hundred seventy-eight initiates were inducted into the American College of Surgeons at its Boston meeting of 1950. Included in that number were the following Michigan doctors: M. W. Alcorn, M.D., Bay City, W. O. Badgley, M.D., Lansing, Alexander Blain, III, M.D., Detroit, D. C. Burnham, M.D., Detroit, W. J. Butler, M.D., St. Joseph, Q. A. Capano, M.D., Detroit, T. J. Cox, M.D., Ionia, F. C. Cretsinger, M.D., Kalamazoo, H. F. Crossen, M.D., Detroit, A. A. Darmstaetter, Jr., M.D., Birmingham, P. E. Derleth, M.D., Detroit, E. F. Eldredge, M.D., Detroit, E. P. Ellias, M.D., Dearborn, D. B. Galerneau, M.D., Centerline, H. H. Gass, M.D., Detroit, G. K. Glasgow, M.D., Detroit, Jack Hoogerhyde, M.D., Grand Rapids, D. C. Howe, M.D., Sault Ste. Marie, E. K. Isbey, M.D., Centerline, A. E. Lamberts, M.D., Grand Rapids, W. A. Lange, M.D., Detroit, A. G. Lasichak, M.D., Detroit, Manuel Levin, M.D., Detroit, S. S. Levine, M.D., Detroit, R. H. Lillie, M.D., Ann Arbor, H. A. Machin, M.D., Kalamazoo, H. G. McClintock, M.D., Ann Arbor, H. D. McEachran, M.D., Iron Mountain, S. L. Moleski, M.D., Grand Rapids, R. T. Murphy, M.D., Detroit, M. M. Musselman, M.D., Eloise, A. S. Narotzky, M.D., Ishpeming, R. A. Poirier, M.D., Detroit, D. A. Pollock, M.D., Port Huron, M. S. Roberts, M.D., Kalamazoo, R. G. Robinson, M.D., Detroit, G. L. Schaiberger, M.D., West Branch, Geza Schinagel, M.D., Detroit, M. S. Sharp, M.D., Lansing, M. W. Shellman, M.D., Grand Rapids, E. R. Sherrin, M.D., Detroit, H. E. Sloan, Jr., M.D., Ann Arbor, P. W. Smith, M.D., Ann Arbor, A. L. Stanley, M.D., Lansing, E. L. Stefani, M.D., Detroit, R. S. Steffe, M.D., Flint, C. S. Stevenson, M.D., Detroit, N. H. Sullenberger, M.D., Pontiac, D. C. Thomson, M.D., Ann Arbor, M. B. Tidey, M.D., Grand Rapids, A. H. Ulmer, Jr., M.D., Port Huron, and R. R. Wessels, M.D., Birmingham.

* * *

J. S. DeTar, M.D., Milan, Councilor of the 14th District, presented the following talks during the months of October and November: October 9, Detroit Association of Insurance Agents, on "Socialized Medicine in the Light of the Hoover Commission Report"; October 18, Michigan State College Extension Groups, Ann Arbor, on "Socialized Medical Care for the People";

October 23, American Legion, Milan, on "The Veteran and Socialized Medicine"; October 24, Tecumseh Rotary Club, on "Do We Want Socialized Medicine, or Don't We?"; November 1, Daughters of the American Revolution, Jackson, on "Socialized Medicine; Do We Really Want It?"; November 2, Monroe Woman's Club, on "A Critical Review of the Socialized Medicine Problem"; November 3, Livingston County Medical Society on "Problems of the Profession in 1950"; November 7, Wyandotte Rotary Club on "Socialized Medicine in the Light of the Hoover Commission Report"; November 7, Wyandotte Woman's Study Club, on "Today is the Day"; November 8, B'nai B'rith, Pontiac, on "A Critical Review of the Problem of Socialized Medicine in the Light of the Hoover Commission Report Findings"; November 14, Monroe Rotary Club, Monroe, on "You Are The Doctor"; and on November 15 before the Monroe Kiwanis Club, Monroe, "Do We Want Socialized Medicine, or Don't We?"

* * *

"**L. Fernald Foster, M.D.,** Bay City, Secretary of the Michigan State Medical Society, did a very able job of answering the advertisement of the CIO National Health Committee—whatever that is—in a fifteen minute radio broadcast on November 1 in Detroit, a union stronghold."—AMA Secretary's Letter (G. F. Lull, M.D.), November 13, 1950.

* * *

The Sixth National Conference on Rural Health, sponsored by the American Medical Association, will be held at the Peabody Hotel, Memphis, Tenn., February 22-23-24, 1951.

* * *

The American Urological Society's south central branch will hold its seminar in Dallas at the Adolphus Hotel, January 29-February 2. For program write R. E. VanDusen, M.D., Chairman, 721 Medical Arts Building, Dallas, Texas.

On Diagnosing Pulmonary Tuberculosis . . . "Patients with minimal disease may raise no sputum or the small amounts obtained may be repeatedly negative by direct smear. It is recommended that patients submit at least four or five single specimens. If no acid-fast bacilli are found by direct smear, one should immediately submit either sputum or fasting gastric contents to be examined by culture and guinea pig inoculation."—From *Is It TB?*, a pamphlet on the diagnosis of pulmonary tuberculosis prepared for general practitioners by the American Trudeau Society — John W. Towey, M.D., Pinecrest Sanatorium, Powers, Committee Chairman.

Copies are available from local and state tuberculosis associations.

Michigan Tuberculosis Association

The Annual Cancer Course at the University of Michigan Medical School will be held at the University Hospital, Ann Arbor, Michigan, January 16-19, 1951. The teaching program is divided as follows:

General Lectures: (Speakers to be announced later).

Clinic Sessions: (Small groups). Demonstration of patients.

Symptomatology, gross appearance of lesions, methods of examination, of biopsy, evaluation of clinical status, indications for treatment. Didactic lecture methods will not be used in clinic sessions.

Pathology: Microscopic pathology. Emphasis on what constitutes adequate biopsy material, proper procedure of biopsy, evaluation of degree of malignancy, estimation of clinical course, etc.

Round table discussion of the work each day.

Further information and application blanks may be obtained from Dr. H. H. Cummings, Chairman, Department of Postgraduate Medicine, University Hospital, Ann Arbor, Michigan.

* * *

Russell N. DeJong, M.D., of Ann Arbor, Michigan, is the Editor-in-Chief of the new official publication *Neurology* just announced by the American Academy of Neurology. The first issue will be the January, 1951 number.

Congratulations, Editor DeJong!

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

SURGERY OF THE SHOULDER. By A. F. DePalma, M.D. James Edwards Professor of Orthopedic Surgery and Head of the Department, Jefferson Medical College, Philadelphia; Attending Orthopedic Surgeon, Jefferson Medical College Hospital, Philadelphia, Methodist Episcopal Hospital, Philadelphia, St. Agnes Hospital, Philadelphia. With 454 Illustrations. Philadelphia: J. B. Lippincott Co., 1950. Price $17.50.

Orthopedic surgeon DePalma has assembled an amazing amount of useful material, profusely illustrated with fine photographs, accurate anatomical and operative sketches and pathological plates in the 424 pages of this volume. This treatise should become a classic, very useful to the medical student as a source book, and of great value to the orthopedic surgeon and the physician who has a good percentage of traumatic work in his practice.

Each of the eleven chapters has a very comprehensive bibliography, in spite of the complete manner in which every possible derangement of the shoulder is discussed. An introductory chapter on embryology is followed by exceptional new work of the author on anatomical variations of the shoulder ligaments, capsule and muscles, stressing the degenerative lesions of the cuff and of the scapulohumeral joint, with his own observations derived from a large series of anatomical dissections and autopsies.

Frozen shoulder, bicipital tenosynovitis, calcareous

tendinitis with their variations, are well handled as to diagnosis and treatment, with a warning against manipulation of the frozen shoulder. Dislocations and fractures are well illustrated and discussed, with fine illustrations of the non-operative and operative treatment.

The section on shoulder pain of neurogenic origin and obstetric paralysis has some original ideas of the author on cervical rib syndrome, scalenus anticus syndrome, subcoracoid pectoralis minor syndrome and costoclavicular syndrome which are very practical, and the differential diagnosis of cervical intervertebral disc injuries. Bone tumors of the shoulder joint and surgical approaches and procedures conclude this fine work, both topics being presented completely, but avoiding unnecessary detail. S. B. W.

BRONCHOESOPHAGOLOGY. By Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S., Honorary Professor of Bronchoesophagology and Laryngeal Surgery, Temple University, Philadelphia; and Chevalier L. Jackson, M.D., M.Sc., F.A.C.S., Professor of Bronchoesophagology and Laryngeal Surgery, Temple University, Philadelphia. 366 pages with 260 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $12.50.

The intensely growing interest in bronchoscopy and the exhaustion of the current texts has led the authors to produce another volume. All the very latest techniques and procedures are incorporated. The book is plain in style, well illustrated, and directly to the point. It shows in detail the necessary things to do for a successful operation, and helps to a true understanding of what the operator sees. A wonderful aid and an excellent text.

THE OTHER SIDE OF THE BOTTLE. By Dwight Anderson. New York: A. A. Wyn, Inc., 1950. Price $3.00.

Mr. Anderson has given us a most valuable addition to the story of Alcoholics Annonymous. He tells of the condition of the true alcoholic, the depths to which he goes, and the rebirth when he is finally accepted and uplifted by that great group of hard-working persons who make and keep their own salvation by the continuation of service at every conceivable inconvenient hour. The worker in this field is doing a reconstruction of humanity unsurpassed in this branch of endeavor. This book is very interesting for the person interested in a well-told problem, and an inspiration to the groping derelict.

PRINCIPLES OF PUBLIC HEALTH ADMINISTRATION. By John J. Hanlon, M.S., M.D., M.P.H., Associate Professor of Public Health Practice, School of Public Health, University of Michigan and Chief Medical Officer and Associate Chief of Party, Bolivia, The Institute of Inter-American Affairs. 48 Illustrations. St. Louis: The C. V. Mosby Co., 1950. Price $6.00.

Another book by a Michigan author. This textbook is very complete, giving the background and a survey of public health methods and achievements in America.

The first part of the book is devoted to organizational considerations, professional factors, management, legal considerations and the governmental aspects of public health. These topics require three and six chapters, respectively.

The second half of the book, twelve chapters, is devoted to specific problems and material such as vital statistics, control of communicable diseases, environmental health, public health, nursing, to mention just a few.

Dr. Hanlon's literary style is very good, and his book is replete with tables, statistics and much general information—an outstanding contribution.

Classified Advertising

$2.50 per insertion of fifty words or less, with an additional five cents per word in excess of fifty

WANTED: Nurse experienced in managing small hospital. Living quarters. Excellent salary. Contact Box 8, 2020 Olds Tower Building, Lansing 8, Michigan.

WANTED: Woman physician to do obstetrics and pediatrics; assist older well-established FACS. Excellent hospital facilities; salary and percentage from start. Minnesota license or National Boards, Parts 1 and 2. Suburb of Twin Cities; apartment available. Wonderful opportunity for future. Contact: Box 5, 2020 Olds Tower, Lansing 8, Michigan.

M.D. WANTED: Good opening for young doctor of medicine in Colon, Michigan; 1,002 population, located in good farming and resort community. No other doctor within ten miles; three hospitals within 25 minutes drive; five churches, twelve-grade school on the University and North Central Association list; two factories, active Lions Club, good bank and theater. Excellent opening for the right man. Contact: Gamble's Drug Store or Charles Williams, Village Clerk, Colon, Michigan.

NEEDED: A young Doctor of Medicine can find an excellent opportunity in Ubly, Michigan. Our former doctor of forty years passed away. We have a population of eight hundred and located in an agricultural area. Have a high school, milk plant, elevator and electric generating plant. Hospital in Bad Axe, Michigan. Contact Village President.

WANTED: Young physician who has completed one year of internship and has finished military service or draft exempt who would like to be associated in a group that has its own clinic and sixty-bed hospital with twenty bassinets. Our group preserves the independence of solo practice, yet gives the usual group advantages. Opportunity to develop in regular branches of medicine and surgery while carrying on a good practice. Excellent remuneration with guarantee. Location—Metropolitan Detroit area. Position available immediately. Write Box 7, Michigan State Medical Society, 2020 Olds Tower Building, Lansing 8, Michigan.

WANTED PHYSICIAN, G.P. looking to specialty later. A Clinic-Hospital group. Young, married preferred. Michigan registration mandatory. Can furnish quarters for apartment in hospital, and food. Dearborn Clinic and Diagnostic Hospital, 4840 Maple Road, Dearborn, Michigan.

Index to Volume 49

AUTHOR'S INDEX

CONTRIBUTED PAPERS

A

R

S

T

U

V

W

BON SECOURS HOSPITAL CLINIC DAY

CANCER COMMENT

COMMUNICATIONS

DETROIT PHYSIOLOGICAL SOCIETY

THE DOCTOR'S LIBRARY

EDITORIAL COMMENT

EDITORIALS

IN MEMORIAM

MICHIGAN'S DEPARTMENT OF HEALTH

MICHIGAN MEDICAL SERVICE

MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

MICHIGAN STATE MEDICAL SOCIETY

MILITARY MEDICINE

MISCELLANEOUS

POLITICAL MEDICINE

PRESIDENT'S PAGE

PUBLIC RELATIONS

WOMAN'S AUXILIARY

YOU AND YOUR BUSINESS

Index to Advertisers